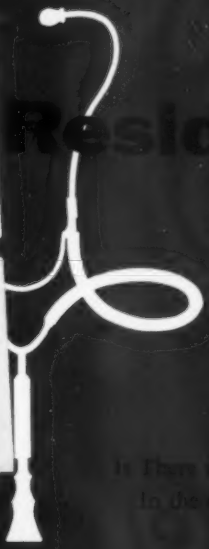
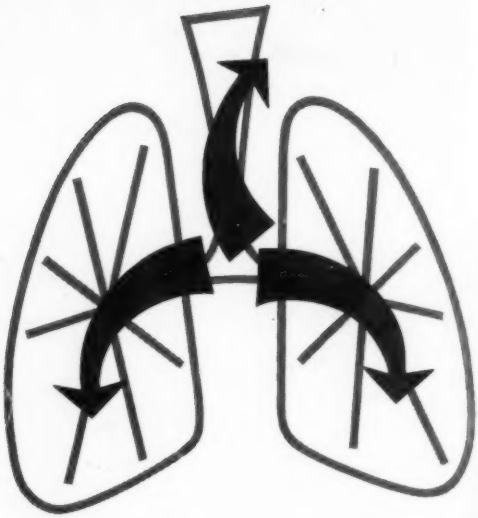


Resident Physician

December 1958, Vol. 4, No.

Journal for the Hospital Staff Officer

CHIEF OF SERVICE, RESIDENT AND INTERN



3-way action helps asthma patients stay symptom-free

To keep your bronchial asthma patients symptom-free and on the job, an antiasthmatic must provide three therapeutic actions—bronchodilitation, vasoconstriction and mild sedation. Just such comprehensive control is available with Tedral.

Here is how each of Tedral's three ingredients acts specifically on a major symptom—

1. bronchial constriction *relieved with theophylline* (*130 mg.*)
2. mucous congestion *reduced by ephedrine hydrochloride* (*24 mg.*)
3. apprehension *allayed with phenobarbital* (*8 mg.*)

No *single* drug can equal Tedral in providing continuous protection against bronchial asthma symptoms.

dosage: 1 or 2 tablets every 4 hours. Tedral Enteric Coated (delayed action) administered together with Tedral (plain) at bedtime protects your patient all night.

Tedral®

the dependable antiasthmatic

WARNER-CHILCOTT
MORRIS PLAINS, N.J.

December 1958, Vol. 4, No. 12

Contents

Resident Physician

December 1958, Vol. 4, No. 12

Articles

The Resident Physician is published monthly on the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Boulevard, Manhasset, New York. Accepted as controlled circulation publication at East Stroudsburg, Pennsylvania. If undelivered, please send form 3579 to Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

Of course, women like "Premarin."

THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

The patient isn't alone in her devotion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing – "Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

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Resident Physician

Departments

A Summary Report on

CORTROPHIN®-ZINC

(Corticotropin-Alpha Zinc Hydroxide)

Description: A unique patented electrolytic process (developed by Organon research) produces a complex of *alpha* zinc hydroxide and corticotropin. This complex offers considerable advantages for practical ACTH therapy.

Characteristics: New Cortrophin-Zinc provides corticotropin of unsurpassed purity with low foreign protein content. This reduces the risk of sensitization reactions.

Since about 5% of the corticotropin is uncombined, onset of clinical response is rapid. But the balance, present as a complex of alpha zinc hydroxide, provides a prolonged action so that the effective time span of a single dose is usually several days. Injection of the new electrolytic Cortrophin-Zinc is virtually painless.

Pharmacology: A potent stimulator of cortical activity, Cortrophin-Zinc *does not depress* functioning of the suprarenal glands. Unlike the corticosteroids, adrenocorticotropic hormone arouses the adrenal glands to produce *natural* steroids in natural proportions. In a 5-year study of patients on ACTH therapy, no case of adrenal *or pituitary* depression or atrophy has been observed.

Because Cortrophin-Zinc is virtually painless on injection and its prolonged action obviates frequent injections, it is now practicable to use Cortrophin-Zinc in most of the indications where formerly reliance has been on corticosteroids. This freedom from apprehension of deleterious depressive effects permits clinical use of valuable hormone therapy on a broader scale than has been possible heretofore.

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Dosage should be individualized, but generally initial control of symptoms is obtained with a single injection of 40 units of Cortrophin-Zinc daily until control is evident. Maintenance dosage is generally 20 units (or less) twice a week.

Use of Cortrophin-Zinc with oral steroids is now recommended as a safety measure to supply the important suprarenal stimulation and lessen the hazard of atrophy. Periodic use of Cortrophin-Zinc is advocated with all steroid analogs, such as cortisone, hydrocortisone, prednisone, prednisolone, methylprednisone, and triamcinolone.*

Supply: 5-cc vials containing 40 and 20 U.S.P. units of corticotropin per cc; 1-cc ampuls containing 40 and 20 U.S.P. units of corticotropin, with sterile disposable syringes.

*Write for complete literature and bibliography containing specific dosage schedules to:

Medical Department

ORGANON INC. • Orange, N. J.

Journal for the Hospital Staff Officer

Resident Physician

December 1958, Vol. 4, No. 12

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lue to resident physicians.
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e manuscript should be
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Resident Physician

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J. ADRIANI, M.D., Director, Department of Anesthesiology, Charity Hospital of New Orleans.

MAX S. SADOVE, M.D., Director, Department of Anesthesiology, University of Illinois.

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MARION B. SULZBERGER, M.D., Professor and Chairman, Department of Dermatology and Syphilology, New York University Postgraduate Medical School.

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GEORGE ENTWISLE, M.D., General Practice Program, University Hospital, Baltimore, Md.

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JOHN C. LEONARD, M.D., Director, House Staff Education, Hartford Hospital.

CHARLES F. WILKINSON, M.D., Professor of Medicine, New York University Postgraduate Medical School; Director, Fourth Medical (N.Y.U.) Division, Bellevue Hospital Center.

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ALAN F. GUTTMACHER, M.D., Director, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City.

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DERRICK T. VAIL, M.D., Chairman, Department of Ophthalmology, Northwestern University Medical School.

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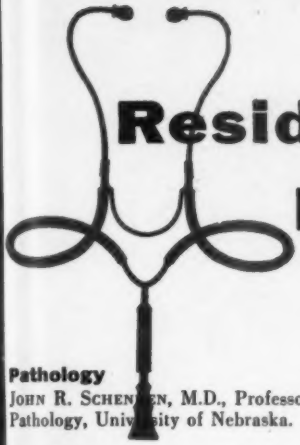
HAROLD A. SOFIELD, M.D., Professor of Orthopedic Surgery Northwestern University Medical School.

Otolaryngology

DEAN M. LIERLE, M.D., Chief, Department of Otolaryngology and Maxillofacial Surgery, State University of Iowa.



Resident Physician

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JOHN R. SCHEN[illegible]EN, M.D., Professor of Pathology, Univ[illegible]sity of Nebraska.

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JAMES MARVIN BATY, M.D., Physician-in-Chief, Boston Floating Hospital.

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HERMAN E. HILLEBOE, M.D., Commissioner of Health, State of New York.

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HOWARD E. SNYDER, M.D., The Snyder Clinic, Winfield, Kansas.

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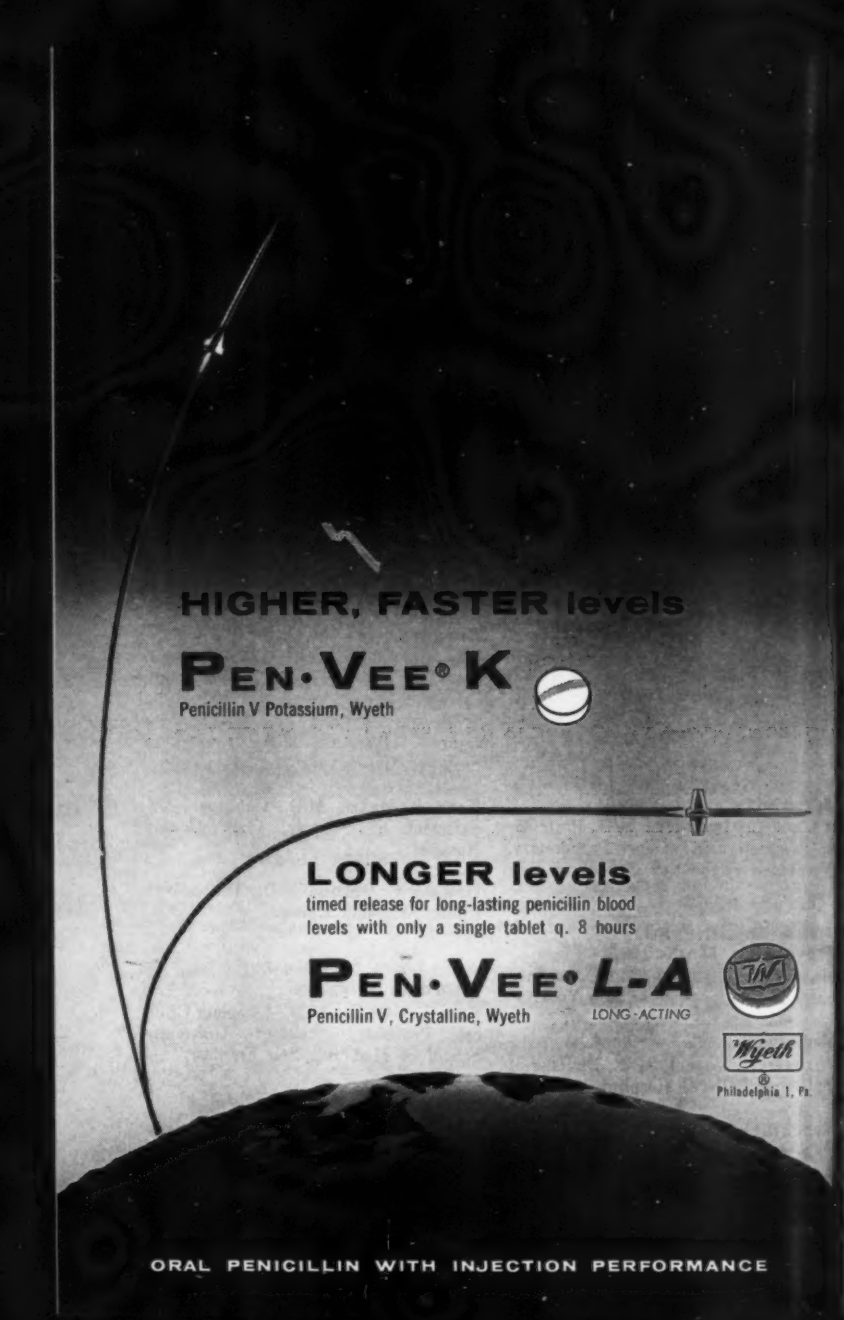
PAUL C. SAMSON, M.D., Associate Clinical Professor, Stanford University School of Medicine, San Francisco.

Urology
HERBERT B. WRIGHT, M.D., Chief of Urology, Evangelical Deaconess Hospital, Cleveland.


HIGHER, FASTER levels
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timed release for long-lasting penicillin blood levels with only a single tablet q. 8 hours
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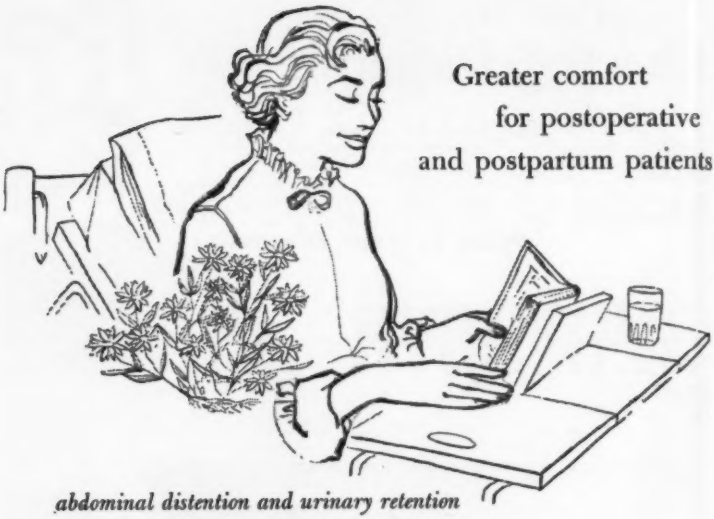
ORAL PENICILLIN WITH INJECTION PERFORMANCE

Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).



Greater comfort
for postoperative
and postpartum patients

abdominal distention and urinary retention
can often be prevented or promptly relieved
—with less need for uncomfortable enemas and catheters

Urecholine®

Chloride
(Bethanechol Chloride)

'Urecholine' helps restore normal function after surgery and childbirth by increasing the muscular tone of the gastrointestinal and urinary tracts. Postoperative "gas" pains can frequently be prevented or promptly relieved—with less need for uncomfortable enemas, intubation, and suction apparatus. Micturition is facilitated—without the discomfort and risk of infection inherent in catheterization.

Administration and dosage: may be given prophylactically or therapeutically after surgery or childbirth. Usual oral dosage: 10 to 30 mg. three or four times daily. Usual subcutaneous dosage: 5 mg. three or four times daily.

Other indications: gastric atony and retention following vagotomy and other surgical procedures; chronic functional urinary retention due to atony without obstruction; megacolon, including congenital megacolon (Hirschsprung's disease); certain cases of paralytic ileus; to counteract side effects of antihypertensive ganglionic blocking drugs.

Supplied: 5 mg. and 10 mg. tablets, bottles of 100; 1-cc. ampuls containing 5 mg.

Urecholine is a trade-mark of MERCK & CO., Inc.

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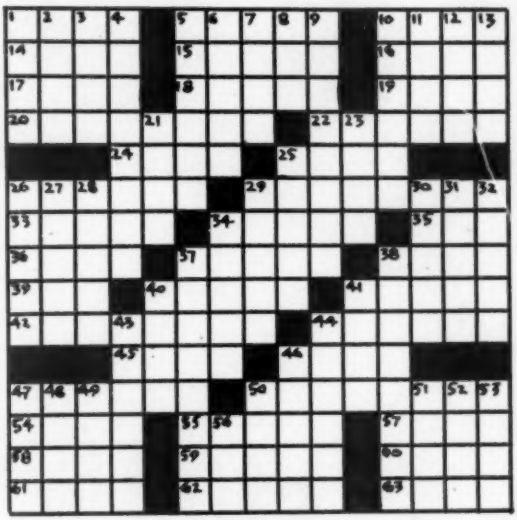
Resident Relaxer

(Answer on Page 183)

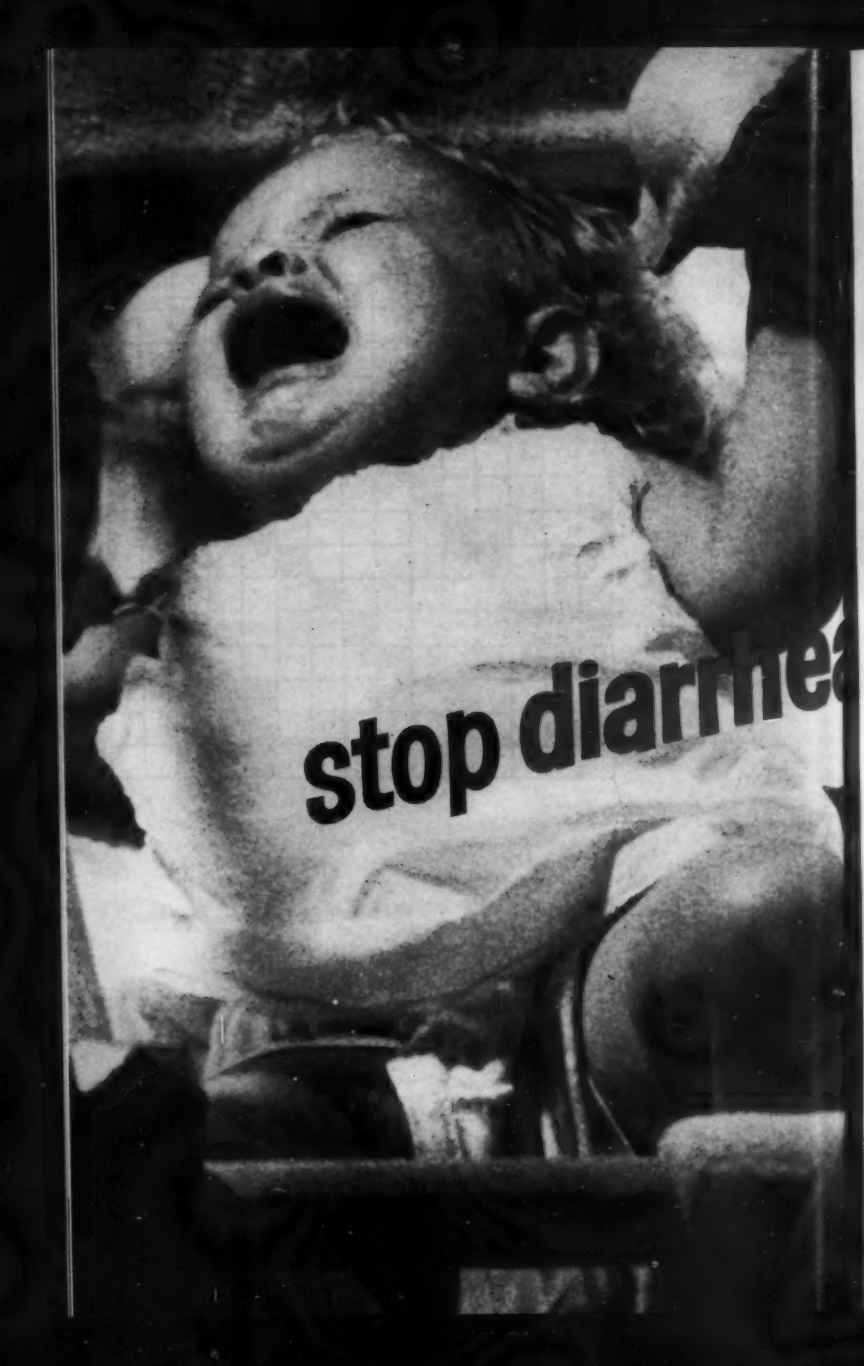


ACROSS

1. Suffering
5. Compound formed from alcohol and acid by removal of water
8. Treponema (abbr.)
14. Upon
15. One who cares for the sick
16. Roué
17. Baglike organs
18. Personal belongings
19. Declare positively
20. Study of relation of organisms to their environment (bionomics)
22. Act of yawning
24. Crippled
25. Small insect
26. A sugar isomeric with glucose
29. Pierce through and through
30. Instrument for measuring
31. Wading bird
32. An alkaloid (suffix)
33. Precious stone
34. Blood.....
35. Ne.
36. Iodine, dubhium (symbols)
37. Ground grain
38. Skin (comb. form)
39. Marked by assonance
40. Native of Libya
41. A stomach (pl.)
42. The knee
43. Relax carelessly
44. Uneasy
45. Organ of respiration
46. Mental impressions
47. Relating to the ileum (prefix)
48. Acidity
49. Potassium nitrate
50. Fervor
51. Plateau
52. Web-footed bird (pl.)
53. On the outside (prefix)

DOWN

1. Position
2. Anatomy (abbr.)
3. Skin disorder
4. Science of classification of diseases
5. Instrument for cutting urethral strictures
6. Rushing motion
7. Flat plate
8. Especially (abbr.)
9. Giving vibrant sound on percussion
10. Bundle of nerve fibers (pl.)
11. Talk as if mad
12. Pieced out
13. External layer of olfactory lobe of the brain: .... olfactorius
21. Lanthanum, selenium (symbols)
23. Of sound mind
25. Concede
26. Obstinate pustular eruption
27. Extols
28. Syllable used to express first heart sound in auscultation (pl.)
29. Confidence
30. Passionate
31. Tumor composed of fibrous tissue
32. Xe.
34. Money
37. A paresthesia, as of creeping insects
38. Atomize
40. Bite repeatedly
41. Force
43. Gout in the shoulder
44. One who leases
46. Cogwheels
47. Shut violently
48. Dark brown color
49. Radon, oxygen, sulfur (symbols)
50. Meshwork of nerve fibers
51. Electricity (abbr.)
52. Gluteal region
53. Alone
56. Expire


stop diarrhe

—Continued from page 34

of RESIDENT PHYSICIAN by Edna B. Bannehr entitled "Residents Are *Serious* People!" I am curious to know more about the Registered Medical Secretary title which Miss Bannehr has used with her name, and would appreciate it very much if you would be so kind as to tell me where I might secure detailed information about obtaining such a designation. I have been employed as a medical secretary for about eight years and since I plan to stay in the academic medical world, becoming "registered" seems intriguing to me. If you do not have the particulars on this subject, would you be so kind as to tell me how I might communicate with Miss Bannehr? Thank you very much for your kindness.

(Mrs.) Freida M. Smith
Portland, Oregon

• *We sent your letter to Miss Bannehr and received this reply:*

I am sure if the young lady who wrote to you inquiring about the National Registry of Medical

Secretaries would write to them at this address: 725 Boylston Street, Boston 16, Massachusetts, they will send her the necessary information regarding her registration. Since I do not know the policy regarding advertising I think it would be much better if the organization sent her information, rather than having it come from me, since I am not an officer or anything in the organization.

Edna B. Bannehr, RMS
Harbor General Hospital
Torrance, California

Legend and Fact

I have been meaning to drop you a note re one of the questions in "Mediquiz" appearing in the RESIDENT PHYSICIAN for June. This is question No. 29 having to do with "early signs of excessive exposure to x-ray or radium." The answer given that such excessive exposure can best be detected by periodic blood counts perpetuates a medical legend. Actually the changes which follow exposure to chronic irradiation are very poorly detected by rou-

—Concluded on page 46

release from pain
and inflammation with

BUFFERIN® IN ARTHRITIS

salicylate benefits with minimal salicylate drawbacks

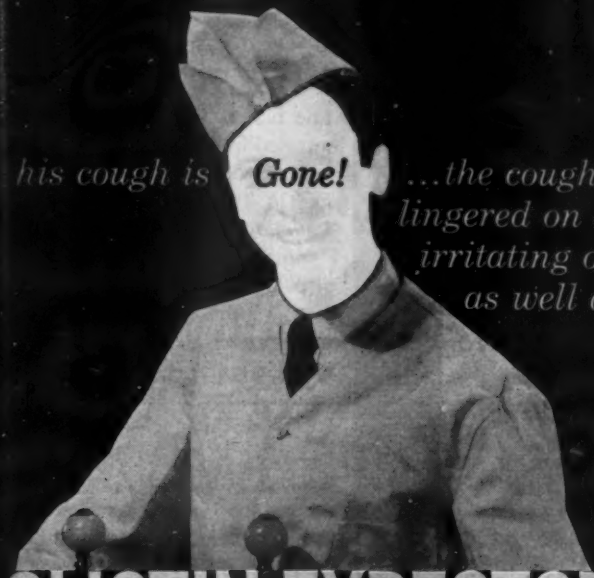
Rapid and prolonged relief—with less intolerance. The analgesic and specific anti-inflammatory action of BUFFERIN helps reduce pain and joint edema—comfortably. BUFFERIN caused no gastric distress in 70 per cent of hospitalized arthritics with proved intolerance to aspirin. (Arthritics are at least 3 to 10 times as intolerant to straight aspirin as the general population.[1])

No sodium accumulation. Because BUFFERIN is sodium free, massive dosage for prolonged periods will not cause sodium accumulation or edema, even in cardiovascular cases.

Each *sodium-free* BUFFERIN tablet contains acetylsalicylic acid, 5 grains, and the antacids magnesium carbonate and aluminum glycinate.

Reference: 1. J.A.M.A. 158:386 (June 4) 1955.

ANOTHER FINE PRODUCT OF BRISTOL-MYERS



CLISTIN EXPECTORANT

—with its antitussive-antihistaminic-expectorant actions—tackles coughs that "hang on" after colds—coughs of allergic or non-allergic origin.

CLISTIN EXPECTORANT is pleasantly fruit flavored, lemon-yellow colored, non-narcotic—does not upset the stomach.

Each 5 cc. contains: Clistin® Carbinoxamine Maleate 2 mg., Ammonium Chloride 120 mg., Sodium Citrate 120 mg., Potassium Guaiacolsulfonate 60 mg., Chloroform 0.01 cc., Benzyl Alcohol 0.3%.

McNEIL LABORATORIES, INC. PHILADELPHIA 32, PA.

—Concluded from page 41

tine blood counts. If you are interested in documentation of this, I refer you to an article appearing in the *Journal of Clinical Pathology,* Vol. 7, p. 267, 1954.

Since "Mediquiz" has a wide circulation among young physicians, perhaps it is not wise to perpetuate this dependency on blood counts as a means of detecting damage. The use of regular physical measurements of radiation detection through the wearing of a "badge" is the only dependable safety measure currently available. It has been shown that decrease in gonadal weight of animals which have been chronically exposed is a good index of damage, but to transfer this into a feasible test in humans presents slight difficulties.

Paul W. Spear, M.D.
Chief, Medical Service
Veterans Administration Hospital
Brooklyn, New York

• *The editor is in complete agreement with Dr. Spear's point of view and regrets that this particular answer was included in "Mediquiz." It escaped his attention.*

Perrin H. Long, M.D.

Editor's Page

The Hopeless Case

Recently, "The Management of the Hopeless Case" was discussed by Dr. Roland Gibson of Winchester, England, before the Section of General Practice of the Royal Society of Medicine in England (*Proc. Roy. Soc. Med.*, 51, pp. 111—, 1958). He pointed out that " 'Hopeless patients' are those of any age group who are suffering from a disease or state, which we, with our present knowledge, regard as incurable." The list of such diseases is decreasing, and in dealing with patients currently classified as "hopeless" as far as outcome of disease is concerned, it was pointed out that those who are hopelessly ill must never be deprived of their last joy on earth, namely hope. Furthermore, in defining "hopeless" in terms of curability, one must realize that we are dealing with (1) individuals whose expectation of life has been markedly diminished by the disease from which they are suffering, and (2) those people who are suffering from a disease from which it cannot be expected they will recover, but who will not have their longevity decreased, or much decreased, as the result of it.

The behavior of the practitioner towards the individual who is hopelessly ill and towards his relatives and/or friends may be of the greatest importance in making the

remaining allotted days of the patient's life bearable, if he comes within the first category, and interesting and even useful if he falls in the second category.

A typical example of the first category would be the case of a patient who had a supposedly operable cancer, but who was found to have metastases at operation. Let's first consider this as happening to a man. The doctor should be first concerned with what he will tell the patient and his family. This is a matter in which the physician must use his best judgment and knowledge of his patient and to time what he plans to say correctly. His patient may be a man having broad interests, which can be wound up or arranged essentially only by the man himself. He may be the type of individual who "must" know. On the other hand, he may be the type who blows up or goes to pieces when faced with adversity. Obviously, with death in the offing, the doctor should be guarded in what he says. In other words, the physician must exercise tact and good sense in deciding what, and how much of what, he will tell his patient.

There is a belief about, that women cannot face the truth, as far as prognosis is concerned, as well as men. The evidence for this belief is almost non-existent. Women are generally much more hard-headed and more inclined to "want to know" because they, too, have to rearrange their lives when faced with death. They have to "figure out who's going to do the housework, the marketing, the cooking, the washing, and the many other things" which make up the work-day of a woman.

As a rule, subterfuges relative to prognosis work much less well with women. They are, as a rule, much more truthful than men, and by virtue of being truthful, expect the truth in return. So here again the physician must exercise great tact and judgment when faced with a woman who is hopelessly ill.

Be it a man or a woman who is creating a problem in communication for the physician, there is one thing the doctor must constantly remember, and that is, that "hope springs eternal in the human breast." The same should be true of the good physician, and he should explore every avenue which opens up relative to the treatment of his patient's disease. Furthermore, he should be sympathetic with his patient, or the patient's relatives, or friends, when they bring him reports of this or that type of "cure." He must not be annoyed, and he must make certain of the truth or falsity of the stories of "cure" before accepting or discarding them. Above all, he should not adopt a superior attitude and dismiss information brought to him as ridiculous (just because he has not heard, or known about it). After the sulfonamides had been introduced into this country, patients died of meningococcal and beta hemolytic streptococcal meningitis because their physicians would not believe newspaper reports that cures were being effected in these infections through the use of sulfonamides. While a doctor should exercise sound judgment relative to the use of new therapeutic measures, he should never permit himself to be so bullheaded about methods of treatment that his patients suffer.

The second category of patient—i.e., the one who suffers from an incurable disease but one which may not shorten his life, is one who really may tax the resources of the doctor. An example of this type of patient is an individual who begins to develop Parkinson's disease in his middle sixties and lives to be eighty or more—a type of medical situation which is becoming more and more frequent. Here the physician should discuss with considerable frankness (but not brutally) the probable course of the disease, and something about how disabling or crippling it will be both mentally and physically. He should outline adequately to the patient and his relatives the current

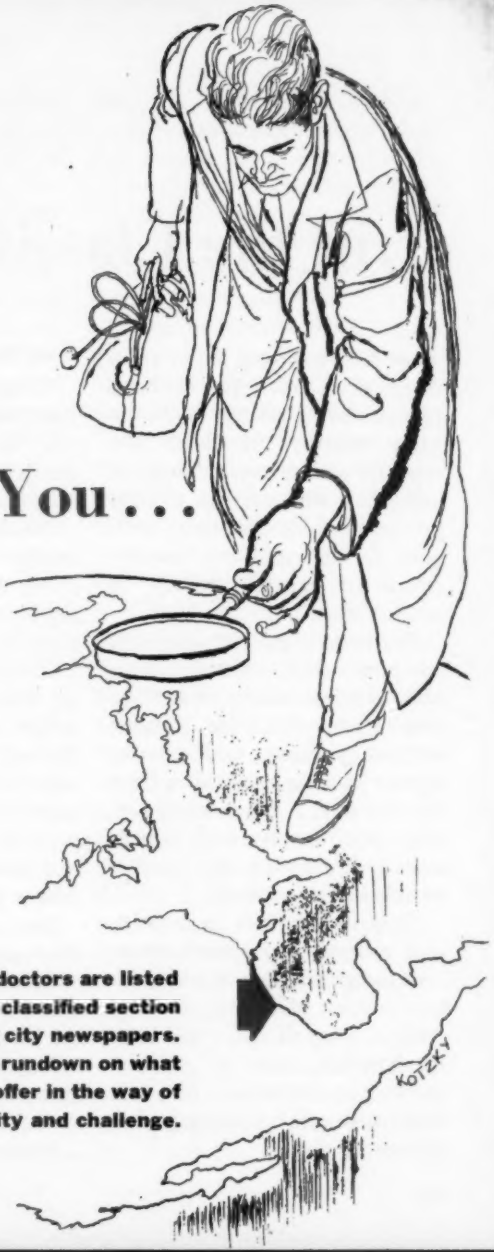
methods of treatment, and if there are several therapeutic approaches, why he is selecting initially the one which he is recommending. Here it is good to point out any possible shortcomings of the proposed therapy, and why, because of lack of great effectiveness, toxicity, etc., it may be necessary in the future to shift to another form of treatment. Furthermore, the physician should assure the patient or his relatives of the fact that he, the doctor, will be constantly on the lookout for any new developments relative to the treatment of this particular "incurable" disease.

Again as with the acutely "hopeless" case, the physician must not get upset when the patient or his relatives and friends bring to his attention this and that report of a "cure" or alleviation of the particular disease in question. It's only natural for them to do so, and the doctor should accept and investigate such reports seriously and good-naturedly. *They are only trying to be kindly, and after all, anything which might help his patient should always be most welcome to the doctor.*

Perrin H. Long,

Is There a

Job For You...



Salaried positions for doctors are listed in the classified section of medical journals and big city newspapers. Here is a rundown on what some of these jobs offer in the way of income, security and challenge.

...in the Classified Ads?

For most residents, future plans do not point to full-time teaching, research or public health. In this same majority are those who want no part of private practice, and others who intended to enter private practice but must postpone the step until they have accumulated enough money to make a start.

For these physicians, classified ads offer a rich source of an almost limitless variety of medical jobs from which to choose; salaried positions, most offering regular hours, a good salary from the first day, a minimum of tension, added benefits such as pension and disability pay, and a stimulating opportunity.

They include jobs in industry —in pharmaceutical firms, insurance companies and others—with labor unions, advertising agencies, medical journals and publishers, in hospitals and as salaried assistants (part-time or full-time) with other practicing physicians.

Drug company

What are these jobs? What do they require and what do they offer? For example, why would a physician take a job with a drug manufacturer?

"Well, to begin with," says teacher - editor - physician, Dr. Perrin H. Long[1], "life within a top-flight pharmaceutical company is exciting and stimulating. These companies spend hundreds of thousands, even millions of dollars on research, and most of the larger companies always have something 'cooking'." Ephedrine, meprobamate and rauwolfia products are examples of industrial research in which physicians took a leading role.

Also cited by Dr. Long was the regular hours of the industry "which allow doctors to do a worthwhile job in medicine without jeopardizing their health."

Major pharmaceutical firms have many jobs and a wide range of duties for the M.D. employee.

Physicians engage in the clini-

cal investigation of drugs both within and outside the organization, supervise and train others in such investigation, and conduct clinical trials throughout the country and even abroad.

They investigate product complaints and usage, correspond with and visit other clinical investigators, address medical conferences, write medical papers, serve as liaison with governmental agencies. They answer doctors' inquiries on drug usage. They aid the doctor in compiling statistical material involving their firm's products and check medical advertising for accuracy.

"The challenge of such a position," one drug company executive writes, "lies in the fact that a man must use all of his medical knowledge in assisting and guiding the research effort of the company." Salary is excellent, and there are numerous fringe benefits.

A recently published survey of the physician in the pharmaceutical industry[2] describes his greatest challenge as advisor to the areas where new drugs are needed. Since the ratio of unsuccessful agents investigated to successful drugs is thousands to one, this direction at the top is crucial.

To be capable of such direction, the doctor must have a broad knowledge of medicine, be able to recognize the opening of avenues of interest leading out of the original path, estimate the capability of laboratory investigators and determine the significance of analytical data.

From the moment the idea for a new drug is conceived, through its use in experimental laboratories, then on humans, right up to its presentation for approval to the Food and Drug Administration, the pharmaceutical doctor plays a vital role.

Insurance doctor

A sheaf of fifteen medical job descriptions on our desk from a typical major insurance company gives ample evidence of the complexity of such an organization's medical department. The obvious for this and any other large organization includes preemployment exams, checking the health of employees, treatment or referral in illness. If the company runs a camp facility for its convalescent employees, and some do, it sends a doctor there on regular visits.

But the bulk of the medical work in a big insurance company centers about a whole complex of medical decisions in the issuance of insurance, reinstatement of

lapsed policies, reduction in rating of substandard insurance, policy changes, questionable claims, group insurance, statistical studies and the company's own medical research program.

The insurance doctor finds himself an advisor to other departments such as law, claims, actuary.

He visits medical schools, hospitals and medical societies to recruit medical personnel and he visits agencies and referees' offices to discuss medical selection matters with field force, cashiers and medical examiners.

He visits high claims rate areas to determine what can be anticipated in the future and what policy can be established to meet the situation, he advises group policyholders on industrial hygiene, suggests methods of organizing dispensaries and other facilities for examination and first aid treatment. He gives medical lectures to lay underwriters and revises the medical guide for examiners.

The big companies issue regular statistical bulletins, pamphlets and brochures on the major diseases and sponsor radio and TV programs. They advertise heavily in various media. The doctor is consulted in each of these enterprises.

Industry

American industry, the world's greatest, has long known that a healthy worker is a productive worker. Its medical program, therefore, has been extensive. In 1947, for instance, a 3-year course of study leading to a degree of Doctor of Industrial Medicine was first instituted at the University of Cincinnati and has since turned out many M.D. specialists in the field.

The duties of the industrial doctor[3] have been described as

- Physical examination.
- Illnesses and injuries.
- Employee contacts (consultations, lectures and articles, appraisal of requests for transfer for medical reasons).
- Industrial hygiene (environmental studies, laboratory procedures, control measures).
- Mental hygiene (testing, consultations, referrals).
- Administrative matters.

In a typical large plant of 28,000 employees, there were in one year, 17,304 physical examinations, 129,780 first aid treatments, 35,412 x-ray exposures.

But the doctor is involved in much more. He works with such departments as personnel, insurance, restaurants, employee publications, safety, job analyses, activities, credit union. The result

is that he learns "his industry as well as his medicine—its physical plant, its echelons of management and supervisory staff, the problems in human relations associated with it, and the distinctive expressions of executive ability that give it place and character."

The smaller companies often pool their funds for a clinic or a doctor to service them jointly. These companies find that a reduction in absenteeism and turnover follows.

The spirit of industrial medicine is well expressed by the doctor who wrote that "Industrial medicine does *not* consist solely of the performance of preplacement examinations, nor does it embrace only the practice of traumatic surgery . . . The industrial physician does not attempt to do something 'to' the worker but tries to work 'for' him and 'with' him."[4]

Labor union

The Sidney Hillman Health Center of New York[5] is an example of the kind of medical service being given to labor union members by their unions in ever increasing degree. In many cases partial management support is written into labor contracts.

In 1949, by special legislative act, the Amalgamated Clothing Workers of America CIO occupied a 6-story building on E. 16 St. in Manhattan and organized a medical clinic. Of 40,000 eligibles, 33,000 were enrolled by 1951. Wives of members were admitted in 1952. Charge to members was $10 a year, one-fourth of 1% of payroll, and drugs taken home at cost.

In 1954, 18 nonspecialists and 56 specialist doctors served on the staff, working 2 to 15 hours weekly, at rates of $5.75 and $7.75 per hour respectively. A re-check of rates in late 1958 showed them unchanged.

Some 12,000 members had been treated in the first three years and 97,043 prescriptions filled and 17,628 x-ray procedures done. The Center had not provided for psychiatric treatment, dental care or treatment covered by workmen's compensation. A Research Advisory Council allocated $300,000 for research, its first project being a study of the relationship between ethnic background and dietary habits to arteriosclerosis.

Medical editor

An interesting position for the doctor in our public-relations-minded world is that of medical editor. Various agencies can be his employer.

lapsed policies, reduction in rating of substandard insurance, policy changes, questionable claims, group insurance, statistical studies and the company's own medical research program.

The insurance doctor finds himself an advisor to other departments such as law, claims, actuary.

He visits medical schools, hospitals and medical societies to recruit medical personnel and he visits agencies and referees' offices to discuss medical selection matters with field force, cashiers and medical examiners.

He visits high claims rate areas to determine what can be anticipated in the future and what policy can be established to meet the situation, he advises group policyholders on industrial hygiene, suggests methods of organizing dispensaries and other facilities for examination and first aid treatment. He gives medical lectures to lay underwriters and revises the medical guide for examiners.

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Pharmaceutical firms have a great deal of work to do in the checking of written material for accuracy. Research papers are written for the company by its research staff for publication either in or outside the company. Protocols are presented to Washington on hearings for drug acceptance. Doctors using the firm's drugs write papers on their findings. Journals are published by most pharmaceutical firms. All this needs medical editorial supervision.

Sometimes an advertising agency handles the pharmaceutical firm's editorial problems. One such, specializing entirely in medicine, produces eight weekly, semi-monthly and monthly pharmaceutical news and information publications. It has some fifteen part-time and six full-time doctors on its staff. The part-time men generally work 20 hours a week and earn $7500-$10,000 a year, which is an apportioned half of the full-time salaries. Much of their work, it must be noted, is administrative, but there is also a necessary job of checking copy for ideas expressed and language and for accuracy of x-rays and diagrams.

This same agency also hires 200 correspondents throughout the world, some of them M.D.'s, some medical students, who, on a part-time, paid basis, cover global medical meetings. Pay for M.D.'s is $50 a day, pro-rated on an 8-hour day for the number of days the convention or meeting lasts. The headquarters chief of the correspondents tells us that turnover is slow and any new hiring "very tight just now."

A growing number of M.D.'s write lay-oriented syndicated medical columns for general newspapers, magazines and news syndicates. Many of them are medical editors for these organs.

M.D.'s are often editors of medical journals, seldom full-time, rather on a part-time, paid basis. M.D. editorial board members are always unpaid. Non-M.D. assistants handle the production problems. A few editors work part-time without pay. Part-time pay varies anywhere from $1500 to "four or five times that amount", as one shocked editor informed us.

Invariably the medical journal editor, paid or unpaid, is an authority in his field who is giving up considerable income elsewhere. These men tend to stay with their posts for many years, though we did find one journal publisher who automatically changes editors every five years to get a fresh clinical approach.

The large publishers of medical texts hire M.D.'s to review medical books that have been written for them. This is a job generally given to an authority who is called upon regularly and is paid either by the year or the manuscript. Fees per manuscript vary with publishers from $50-$250, with turnover slight.

One major publishing company, however, operates in completely atypical fashion. It does now have an unchanging list of M.D. reviewers but choose new men constantly. "Medicine," we were told, "is too complex for one man to know it all."

Furthermore, publishers often call on house staff doctors and even medical students to review the new manuscripts of great authorities, reasoning that the young doctors, too, have a viewpoint that a medical text should try to satisfy. It even pays royalties to doctors who are instrumental in initiating the publishing of a book with a fresh slant. This publisher disregards applications for its hiring, choosing doctors it knows personally as unprejudiced and talented.

The large voluntary medical and health organizations in polio, cancer, heart, diabetes, etc., publish journals, brochures and bibliographies that require M.D. supervision. Here, also, most M.D.'s hired are part-time and paid either yearly, as in the editing of a journal, or per item, as in the writing of a brochure or pamphlet.

We discovered only one major foundation to be interested in future hiring. Its full-time medical chief was newly hired himself and was contemplating a series of pamphlets on examination of the body's parts afflicted by his foundation's disease as well as historical writing on the foundation. He wanted M.D. writers for their special approach. All other foundations contacted had no hiring needs and predicted none.

Some of the big general hospitals have full-time medical editors to polish up the manuscripts of their staff that are being prepared for publication. New York's Roosevelt Hospital is a pioneer in the field. The great clinics, Mayo, Lahey, Hertzler and others have full-time publication sections to do this work.

Hospital administration

Many hospital administrators are M.D.'s. The work pays well, offers great professional and community status and is a job that requires multiple skills and attributes.

Just a glance at the depart-

mentalization in any hospital indicates how varied the superintendent's tasks are. He must relate well to his board of trustees, medical board, doctors, nurses, patients and general employees. He must know the various medical aspects of the hospital and the problems of business management, purchase and supply, physical plant. He must be a fund-raiser (unless in a government facility), a power in the community, the proverbial "all things to all men."

The late Malcolm T. MacEachern in his classic text on hospital management[6] described qualities the hospital director must have. He must be "a person endowed by nature with . . . infinite tact and diplomacy . . . firmness tempered with consideration for the weakness of others . . . an organizer . . . a leader . . . absolutely honorable and just . . . a judge of human nature . . . industrious and interested in his work . . . a man of broad education, neat and tidy in appearance . . . an educator . . . a man of business ability . . . a good buyer . . . of a mechanical turn of mind . . . have an ability to work with others."

In large hospitals there are assistant administrators on various levels, most of them starting at poor salaries but in line for quick advancement, if they merit it, in this wide-open and exacting field. Formal training requirements have raised hospital-medical administration to a specialty.

M.D. assistant

The doctor just out of residency sometimes apprentices himself as a salaried assistant to an older doctor in practice.[7] He has the advantages of security and regular hours with lessened responsibility. And, if he clicks with his senior, he is in good position to work into a partner relationship. Often the employer provides such incidental expenses as car upkeep, medical association fees, malpractice insurance, vacation and sick leave.

These are but a few of the opportunities offered through classified ads. Start reading the classifieds regularly. Perhaps you'll find that perfect opening for your future in medicine.

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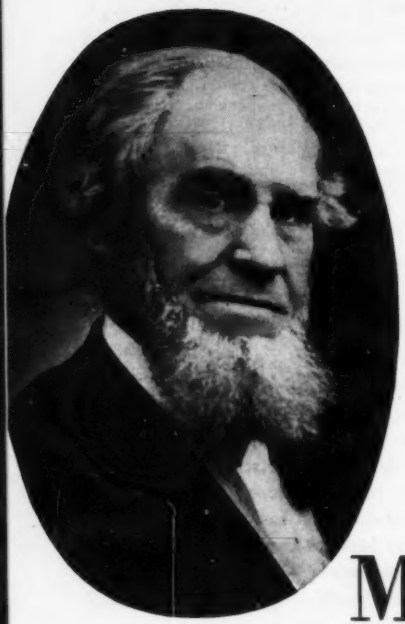
PROTECT YOUR CREDENTIALS

During war and national uprisings, medical records are often lost or destroyed. Because of this, many doctors are today unable to utilize their professional skills because of the loss or destruction of their original credentials and a lack of a protective service in which authenticated copies could be deposited. Therefore, The World Medical Association has established the Central Repository for Medical Credentials to assure that doctors all over the world will always be able to prove themselves medically trained and fully accredited to practice medicine. The American Medical Association has commended the program.

In the United States, the lifetime cost of the service on a one-payment basis to the newly graduated doctor is approximately $60. An actuarial schedule has been established for doctors in the various age groups. A 10-year service rate is also available.

Repository officials suggest that the credentials deposited include official medical school record, medical diploma, and specialist credentials. American doctors should not send their original credentials, but should send photostatic, microfilm, or notarized copies of their original credentials.

Requests for forms and additional information in regard to the Central Repository for Medical Credentials is available from The World Medical Association, 10 Columbus Circle, New York 19, N. Y.



In June of 1828, William Stanley Merrell joined the ranks of Cincinnati pharmacists by opening a modest shop on Western Row, on the edge of town and across from a green woodland.

Cincinnati was then a western outpost that was growing at a brisk pace; in the space of a few years its population had doubled,

MERRELL *of*

The secret of William Merrell's success as a drug manufacturer was not his above average scientific ability or his tremendous energy. As his family and workers well knew, it was the human touch.

reaching well over 20,000 and creating a housing shortage. Settlers came along the Ohio River, the city's commercial lifeline and link with the East and South.

Urban and rural elements flourished side by side. Horse-drawn carriages, wagons and carts rattled over unpaved streets, sometimes having to give way to hogs and cows being driven through town. A newspaper, the *Centinel,* had been founded in 1793, a singing school in 1800 and a symphony orchestra in 1825. Life was not without the mellowing influence of culture.

Merrell had come to the Ohio city from New York State. His new enterprise represented a great deal more than his investment of $200 (though the money had been hard enough to scrape together), for at the age of 30 he was still seeking to establish himself in a field where he could use his scientific training.

He was a man of high ideals who was in the habit of attending church three times on Sunday. When in his twenties, he had eschewed such popular di-

...L of Cincinnati

Merrell plant at Fifth and Butler was completed and occupied in 1894, following a nationwide panic which put the drug company's financial structure to a hard test.

versions as balls and kissing bees, and later was a member of a church group that pledged "entire abstinence from the use of ardent spirits, except for medicine."

This firm morality was coupled with superior mental and physical abilities. Though Merrell was only five feet three and 120 pounds, he could lift several times his own weight.

Mentally, he was in the heavyweight class. A scholar throughout his life, he was keenly interested in chemistry, mineralogy and astronomy. He was in his late seventies when he read to a medical group his recently written paper on "the Causes of All Contagious Infections & Most Epidemic Diseases and Especially of the 'Milk Sickness,' which I hold to be minute animal or vegetable life capable of self-propagation."

He was born in New Hartford, near Utica, New York, in 1798, and had much of his schooling in several New York State towns

Photo dating back to the 1890s shows George Merrell, founder's son, in his office. He died in 1914, after 52 years with the firm and at the end of a period of rebuilding.

and in Cincinnati. After a stint of teaching, he was admitted to Hamilton College in 1819. Geography, English grammar, Latin, Greek and other classical learning occupied his time that was not taken up with chemistry. This was the field that fascinated him, to the extent that he had attended chemistry lectures at the college even before becoming a student.

Journal

Merrell's diary, which he kept from 1814 to 1875, gives a picture of an unassuming, observant and humanitarian individual. His first trip to Cincinnati was in 1814 to take a job with his uncle, Major William Stanley. The adventure was duly recorded in his journal.

"I had hitherto been bred a simple homespun farmer . . . We were taught to govern ourselves rather than be governed by the fear of the rod only. We were instructed in morality both by precept and example and to be mannerly, condescending and obliging to all around us, but I had never been in any company scarce even with boys of my own age, few of whom lived near me. . . . I had been in Utica which was but seven miles distant but twice. . . . I was now about to set out on a long journey to a distant country and was for the first time to depart from a parent's care."

The trip required steady traveling from February 3 till March 25, by sleigh, wagon and barge. The job, in a retail establishment partly owned by Major Stanley, came to an end a few months later with Stanley's death. Merrell also lost out on his share of the major's estate because of a technical error in the witnessing of the will.

Though the young man returned to New Hartford, Cincinnati had left a lasting impression on him. He returned in 1820 and 1823 in hopes of establishing himself in a career, but each time suffered disappointment.

Travels

A May 1823 entry in the diary shows that conditions of travel in those days left much to be desired.

"I reckoned the road from Cleveland to Wooster as bad as could be anywhere found, & my companion swore it was bad as could be, but I find on this public 'state road' sloughs worse than

any there. The clay is trodden up nearly belly deep & is now just stiff enough to suffer my horse to sink to the bottom and then hold him with all its tenacity."

Attempts to get a teaching position took him to Kentucky, and the possibility of manufacturing porcelain took him to Illinois and Missouri. In November of 1825 Merrell returned to New York, but two and a half years later was again on his way to Cincinnati, this time to start a drugstore.

Merrell's first sale brought him three fippenny bits (about 19 cents) and sales for the first week totaled $3.07. A few months later the shop was grossing about $30 a week, which enabled Merrell to hire a clerk. The young fellow was paid $4 a month plus board.

Though Merrell had wanted to be a physician, he found the profession of pharmacist a satisfying one. His great interest in the scientific end of the business turned the shop into a manufacturing pharmacy, and soon he was shipping his products to doctors in other counties and states.

Marriage

Though the business and his continued study of chemistry took up most of his time, he had many friends and enjoyed being with them. Nor was he too busy for romance. In 1831 he married a young lady named Mehitabel Thurston Poor.

The analytical laboratory in 1912. This department was created by George's son Charles, who later became company president.

They had 11 children, the youngest of which was born in 1856. At the time, the family doctor was out and the nurse who had been engaged was on another case. William delivered the baby.

He was an affectionate parent and much concerned with fostering his children's character development.

"Sons Albert & George work at store [the Merrell sales outlet], at putting up medicine, packing Elm, etc.," he noted in his diary. "This gives them employ in the vacation, earns them some money they can call their own, & inculcates the idea of earning."

The sons became respected professional and business men. Stanley, the eldest, had a drugstore in Covington, Kentucky, across the river from Cincinnati. George became president of the Merrell Company, and William was a promising member of the family business when he died at age 25. Albert eventually became professor of chemistry at the Eclectic Medical College of Missouri and also received the degree of M.D. there. The youngest son became a lawyer.

At the age of 77 Merrell still accompanied those of his sons and daughters who were at home to numerous social and cultural events. He kept up a lively and affectionate correspondence with those who had moved away. The business in later years brought

occasional father-son disagreement on certain financial matters, but the elder Merrell, motivated by paternal tenderness, was willing to yield.

Troubles

His affection and sympathy, extending to more distant relatives, to friends, and often to strangers, sometimes brought results which were not always good for his business. In 1856, for example, he employed a young relative who was out of a job and who had "kept himself straight . . . his family are comfortable and happy."

Two months later, however: "J—— still here but as we have help enough without him and we have strong fears of his honesty, which are confirmed by the conviction of all the under clerks, we shall not keep him only through this week."

In 1857 a nephew came to work at the store: "We do not really need such an assistant, but he has become embarrassed in his pecuniary circumstances & cannot meet his engagements. Has to sell his place . . . for what he can get, & is broken down & discouraged, so we employ him out of sympathy to him & family." Three months later: "A new business trouble is at hand, and Nephew —— has got [financially] embarrassed & . . . we must therefore buy his property. . . . This is a great sacrifice to us."

December 1857: "Wesley S— sues me on my endorsement to Dr. T——. See T—— & he promises to protect it certain. An unlucky act of friendship—which past experience should have taught me to avoid."

During Merrell's more than 82 years, he had periods of less-than-perfect health, but for the most part was remarkably strong and well. His diary in 1860 records:

"My health is uniformly better than when 50 years younger and my mind equally active & I think capable of even greater labor or acquirement than at the age of 20. . . . My hair is but little frosted, beard white on the chin & neck, a little bald on the crown."

His daily schedule continued throughout his sixties to include "Rise not till 7:30 at this season [winter]. Family worship by reading the Word & remarks & prayer. Then breakfast at 8.

Thence to business. . . . Home to dinner at 1:30. To supper at 6. Then to store again & write [business correspondence] till 10 or 11. Home, read news a while & to bed from 11 to 12." His "lethargy" distressed him throughout a lifetime of such hours.

On becoming 77, Merrell noted that this was "generally considered a fair old age, but several years below that of my father, and some other members of the family. My health is now very good. I eat with a relish and sleep well. I go to store [Merrell Company] daily at between 9 and 10 A.M., home at 4 P.M. to dinner."

In his seventies he suffered several injuries, two falls on early morning ice, and a violent dashing to the ground by a fast driven horse and buggy. He made a good recovery in each case.

An earlier injury, in 1861, resulted from an encounter with a fellow citizen who evidently did not share Merrell's views on the use of ardent spirits.

"Started home from the store

In the mid-twenties the finishing room was the domain of ladies in long white smocks. They handled the machinery which filled, corked, labeled and conveyed the bottles.

about 11 P.M. and as the ground was covered with sleet I took the middle of the street on the street R.R. track. Between Race and Elm found a small man staggering in the way. Passed him, but after tumbling down he came on after me & trod on my heels.

"I hastened along, and he followed again running upon me. Just below Central Avenue he fell down right in the car track & a car was coming up but little below. I hastened on & stopped to speak to the driver to caution him not to run over the fellow, but while doing so he came up and seized hold of me and we both went down together on the frozen ground, I below and he upon me.

"I soon turned him, at the same time rolled farther from the then passing car. While struggling to get loose from him, as he held on to me, another young fellow ran out from the barracks opposite, pulled me over and asked what in h—l I was doing with that man and before I could answer, struck me a violent blow with his fist in the mouth and then (discovering I think by my voice who it was) ran off into the house.

"I got up and cried, 'Watch, Watch' and soon two watchmen arrived. I told them of the affair and they took the drunken fellow that threw me down to the station house. The other I could not identify. Found that I was badly hurt."

Recovery from a sprained shoulder took many weeks. On a request from the young inebriate's mother, and with a letter of good conduct from the man's employer — but against Merrell family advice — Merrell had the young man released from jail.

Life and times

Politics in early nineteenth century Cincinnati sometimes turned into something our Founding Fathers would have deplored. About the presidential election of 1824: "Today is election for Electors of President and Vice President. . . . In the afternoon much unfair play was used. A mob of the adherents of one of the candidates was formed who excluded all from the polls except the friends of their favorite. Thus some were kept away and others were compelled to reach the polls by stratagem by holding up to view a ticket for the

Jackson electors, and then when reaching the polls voting for Adams or Clay."

In March, 1825, Merrell recorded an unusual Sunday disturbance: "After attending to my duties in the Sab. School I remained in the gallery where our school is tonight that I might preserve good order among the children that remained during service. Just as the sermon commenced a throng of children 2 or 3 hundred in number pressed into the gallery in a most disorderly manner and pushed forward to the front part of it & after remaining not more than ten minutes began to go out again and before service was ended were all dispersed. The cause of this disturbance I was quite unable to guess till after meeting when I learned that Gen. And. Jackson had just arrived in the city and at that time had entered the church below."

Cholera hit the city several times. In 1832: "At 9 o'clock I went up into the city on business and on my way to my house fell in company with our esteemed neighbor Mr. I. Cavalt. He was then in his usual health. On my return, was told that he had the cholera. After dinner [noon] went in to see him, then in the collapsed stage of the disease, & at 6 P.M. he was a cold & livid corpse."

Religion

An influence that strongly affected the drug maker's life was religion. During the 1820's, a period of stirring revivalists, Merrell listened to the stinging calls to forsake sin and hell. Spiritual thirst led him from church to church every Sunday to hear the sermons of Methodists, Presbyterians, Baptists, Roman Catholics. His zeal caused friends to urge him toward theological school.

Finally, he found a haven with the Swedenborgian Church and eventually became one of that group's strongest and most respected members. He taught Sunday School from his twenties until at least the age of 68, officiated at funerals, preached or read sermons in the minister's absence, and was for many terms president of Cincinnati's Swedenborgian Church. Merrell acknowledged in his later years that "I am sustained only by an abiding trust in Him who has hitherto brought

me safely through the storms of life."

For many years he was a patron of the musical life of the city. In 1875 he could not resist the excitement of the city's great May Music Festival, got a last-minute ticket which provided him only with standing room. He heard the music, then went home exhausted, having "paid quite too dear for the whistle."

The previous year he'd gone to see "P. T. Barnum's famous 'Hippodrome' to satisfy my 'boyish' curiosity & perhaps gain some

At the turn of the century: sturdy young lads eye camera while tending drums in which tablets and pills were coated.

knowledge. I was well entertained but one visit to such a show is enough for me."

Honors

Merrell received his A.B. degree at Hamilton College in 1823, and in 1851 an A.M. degree that he might have received a quarter of a century earlier had he requested it. The Eclectic Medical College of Philadelphia gave him an honorary degree of M.D. in 1862 as well as making him a trustee. In 1871 a similar degree was bestowed on him by the Eclectic Medical Institute of Cincinnati, of which he had been president of the board of trustees since 1864.

When the new Eclectic Medical Institute had been organized in 1846, its founders asked Merrell to undertake the improvement and preparation of their medicines. His close connection with eclectic medicine did not, however, distort his perspective on its place among the healing arts. He stated in a minority report, in 1869, to the Ohio Eclectic Medical Association, that "Eclecticism has fulfilled its mission and it is not desirable to get up a book of that kind [a pharmacopœia] which would be a barrier to approaching union."

In the 1840s William Merrell did original research on the resinoid and alkaloidal principles of botanic drugs. He set a standard of pharmaceutical perfection that gained world wide respect for the Merrell firm. In 1877 his company was first to make salicylic acid available to the medical profession in America.

Business

The pharmaceutical business Merrell founded makes a fascinating story in itself. Through it runs the pattern of his persistent chemical experiment, and his patience and fortitude in face of adversity.

His humanitarian nature influenced his business methods, often adding to the pitfalls encountered in a time of economic uncertainty. Diary entries on many occasions give the modern reader cause to be grateful for our modern banking system. 1857: "News that all the Phila., Baltimore, & Boston banks have suspended specie payments. A terrible crisis in money matters. Think it will result in a general suspension through the U. S. similar to that

of 1837. How business men are to meet their obligations it is hard to see."

Two weeks later: "No money on hand except that of suspended banks. Send out bills against . . . but collect nothing. Collect of a mercantile house $12 and borrow $30, to distribute to workmen tonight. A gloomy time in the monetary world." 1860: "Banks in Phila., Va., & Boston suspended & a general derangement of financial affairs seems impending and we are not well prepared for it." 1861: "Business through the week has been very fair, but customers send Ill. & Mo. & Southern money which is from 5 to 20% discounted, and we have to share at least the loss on it."

1862: "The raid of Morgan into Ky. has produced a great excitement & consternation and has doubtless had some effect on business." 1868: "Money comes in slowly and our sight drafts which we got discounted on 22nd have many of them come back unpaid—to more than half the amt. sent out. Never for two or three years have we had so large a proportion not accepted & honored. Money matters are exceedingly stringent all over the country, more so than since 1857."

Despite the crises, the business managed to grow. Orders came from all directions of the compass, and the first big order from overseas was filled in 1862. Merrell's diary stops in 1875. On September 4, 1880, he died.

A few months later, 52 years after the firm's founding, the company was changed to a corporation. In the twentieth century, 1938, the Vick Chemical Company, to diversify its enterprise and to provide more far-reaching service to physicians acquired ownership of the Merrell Company.

Today in 1958, dozens of plant-expansions later, the long and interesting history of the founder still infuses The Wm. S. Merrell Company with a special character all its own, a quality that visitors rarely fail to notice.

Clinico Pathological Conference

New York Hospital-Cornell Medical Center

Dr. E. Hugh Luckey, Clinician.

Dr. John G. Kidd, Pathologist.

Dr. E. Hugh Luckey: I shall assume that all of you have had a chance to examine the protocol.

This was a 69-year-old woman who had four admissions to the New York Hospital during an illness of nine months' duration. Her symptoms and signs during this illness were predominantly those of congestive heart failure with dyspnea of pleural effusion, ascites and marked peripheral edema. In spite of the intelligent application of the usual therapeutic measures in dealing with congestive heart failure, this patient had a progressively unfavorable course and eventually intractable failure and death occurred.

I should like to discuss this patient from two standpoints. First, the nature of the heart disease and second, the cause of rapidly progressive course and the terminal events. The cause of this woman's heart disease is puzzling. She was a woman in the 7th decade without previous history of hypertension or pain in the chest on exertion, rheumatic fever or other diseases predisposing to cardiovascular disease. She had the relatively sudden onset of heart failure after essentially an unremarkable health history. The only feature of some note in her past history was the difficulty with varicose veins in the lower extremities leading to ligation of the saphenous veins five years before admission.

What were the characteristics of her heart disease as we observed her in the hospital? First there was marked cardiac enlargement which was said to be generalized. I think we should see the x-rays at this time.

Radiologist: On the initial admission one sees hazy densities in both costophrenic angles, which have the appearance of small pleural effusions. The heart itself is markedly enlarged. It has a flabby, saggy appearance such as would be seen in multichambered enlargement or pericardial effusion, rather than specific chamber enlargement.

Lateral film examination showed a moderate and smooth displacement of the barium filled esophagus, suggesting multichambered enlargement. The aortic shadow is not particularly widened.

Dr. Luckey: We observe that marked generalized cardiac enlargement was present. The blood pressure was 140/90 on her first admission to the hospital and then later in her course blood pressures in the range of 80-90 systolic over 50-60 diastolic were noted. The evidence indicated that there was a persistent low blood pressure during the last three admissions to the hospital.

There was a normal sinus rhythm in the electrocardiogram during the first admission and subsequently the development of auricular fibrillation which persisted throughout the rest of the course. Poor heart sounds and a soft, I assume this means faint, systolic murmur were present at the apex. The pulmonic second sound was greater than aortic second sound. Signs of congestive heart failure were observed with a venous pressure of 240 mm of saline at the angle of Louis. This represents marked venous hypertension. No pulses were palpated below the femoral arterial pulses at any time and there was evidence of calcification in the abdominal aorta.

The EKG showed low amplitude of the QRS complexes. There are the ST-T segment changes which are indicative of myocardial disease, but not specific for any type of myocardial damage. Particularly, there is no definite evidence of myocardial infarction or of ventricular hypertrophy. This is the EKG one would expect to find in a patient with severe myocardial disease. This tracing is compatible with the situation in which there is myocardial involvement in both the right and left sides of the heart.

What are the possible causes

of her heart disease? First, in any lady in the 7th decade with the findings that have been described, by far the most frequent cause would be arteriosclerotic heart disease, or more properly, coronary heart disease. We know that before the menopause women rarely develop coronary heart disease in the absence of hypertension, diabetes, or familial disturbances in lipid metabolism. Yet, coronary heart disease can be seen in exactly the setting we have here—namely in a woman some years past the menopause. However, if coronary heart disease were the cause of this woman's troubles, one would expect to find clear evidence of angina pectoris or coronary insufficiency. Each of us recalls immediately instances of coronary heart disease, even severe myocardial infarction, without pain or other symptoms of coronary insufficiency.

Nevertheless we refuse to make the diagnosis of arteriosclerotic heart disease or coronary heart disease without clear evidence of coronary insufficiency.

This clear evidence of coronary insufficiency must be either a history of pain on effort, a history of a definite myocardial infarction or electro-cardiographic changes that are diagnostic of infarction; ST-T segment changes in the EKG of the type seen here may be due to coronary artery disease but certainly are not diagnostic of this disease.

With this policy we will miss a few instances of arteriosclerotic heart disease in which there is no clear evidence of coronary insufficiency. Nevertheless by this restrictive approach to the diagnosis one will be prepared to detect those instances of hyperthyroid heart disease, of constrictive pericarditis, and of other obscure causes which may be curable. We should not be embarrassed to make the diagnosis of heart disease of unknown cause.

Did this patient at some time have hypertension and over the course of years with the development of heart failure have a fall of her blood pressure to normal levels, during the latter seven months of her course? This phenomenon, so-called "burnt-out" hypertensive disease, is in our experience very unusual. I have never seen an instance in which this took place in the absence of hypotensive drug therapy in which low levels of the blood pressure were present for seven months.

What about constrictive peri-

carditis? There are a number of features of this illness which are compatible with such a diagnosis. First, the patient did have right-sided heart failure with marked venous hypertension. I should like to ask at this point if this patient's venous pressure returned to normal or near normal levels after adequate diuresis? The reason I ask the question is that patients with constrictive pericarditis may have a profuse diuresis and return to optimal body weight without return of the venous pressure to normal. This is a useful clue in the detection of this disease.

Doctor: On one of the later admissions a venous pressure of 90 to 100 mm. was recorded.

Dr. Luckey: This would not be in favor of constrictive pericarditis. But further, the hypotension with a narrow pulse pressure that was noted in this patient is compatible with constrictive pericarditis. The marked cardiac enlargement, although unusual, is seen occasionally in patients with constrictive pericarditis. The EKG is nearly the classical one in constrictive pericarditis but, in itself, is not diagnostic.

Against the diagnosis of constrictive pericarditis is the age of the patient at the onset of symptoms of failure. Constrictive pericarditis seems to occur following pericarditis of youth or at least early middle age and most of the time symptoms of right-sided failure appear earlier than the age of 69. In the series of 78 patients reported by Dr. Paul White from the Massachusetts General Hospital, none of the patients noted first symptoms of failure after the age of 60.

Again, the size of the heart is somewhat against constrictive pericarditis, although as I mentioned, this is occasionally noted.

No paradoxical pulse was elicited. In the great majority of patients with constrictive pericarditis one can note this pulse phenomenon. No calcification has been described in this patient but in approximately 75% of instances of chronic constrictive pericarditis calcification is not detected in routine x-rays. The lateral x-ray projection is usually the one in which we see calcification best.

Infarction

We should consider some of the other causes of heart disease in this age group. We may note that the patient had a number of episodes suggesting pulmonary infarction. Is it possible that this patient developed cor pulmonale on the basis of repeated pul-

monary emboli from thrombi in the venous system of her lower extremities. There is insufficient evidence of disproportionate pulmonary symptons in this patient to support this diagnosis. Since there was considerable evidence of left heart failure I think one can discard cor pulmonale as the cause of underlying heart disease.

Hyperthyroidism I mention simply because of the frequency with which it is missed in older patients. Certainly there is no evidence to suggest hyperthyroidism in this patient. All the evidence points to the fact that she had a very low cardiac output.

Acute bacterial endocarditis occurring on apparently normal valves can lead to rapidly advancing heart failure. But it is evident that this patient has had heart disease for quite a long period of time with no recent constitutional reactions suggestive of infection, and I think one can discard this.

Infiltrative

What about some of the unusual infiltrative processes which may involve the myocardium? First, one may consider amyloid disease. Cardiac involvement is quite common in primary amyloidosis and uncommon in the secondary form. We may see enlargement of the heart to the extent observed here, frank heart failure, hypotension, but we usually detect macroglossia or other evidences of extracardiac amyloid disease. I want to emphasize that evidence of extracardiac amyloid involvement is present in most patients with amyloid heart disease. For that reason, and its rarity in comparison to some of the other processes that we will discuss, I think we can put this aside for now.

Uncommon

The next heart disease of undetermined or obscure origin is that described by Drs. Levy, Von Glahn, and others, known now as the "big heart syndrome." This occurs in middle aged people and is characterized by rapid progression of heart failure, in a setting of cardiac hypertrophy without evidence of hypertension or valvular disease. Actually I think there is nothing incompatible with this syndrome in this entire account. I think the whole story could be due to primary amyloidosis or idiopathic hypertrophy, but both of these are relatively uncommon.

Now is there any form of valvular heart disease with which this course is compatible? Syphi-

litic cardiovascular disease? No. There are no evidences of aortic insufficiency and therefore no evidence of syphilis of the heart. The Mazzini is negative. Pure mitral insufficiency of rheumatic origin without significant stenosis would be an unusual cause for a course of this type. In the first place, one would expect deterioration earlier in life with a degree of mitral insufficiency sufficient to cause the degree of cardiac hypertrophy that we see in this patient. Mitral stenosis? No. There is no evidence that the predominant hemodynamic defect is at the mitral valve. There is no evidence of right ventricular hypertrophy. It should be mentioned, however, that patients with mitral stenosis in the later stages of their course may have hypotension and a narrow pulse pressure such as we see here. In our experience it is very uncommon to observe the disappearance of the diastolic murmur of mitral stenosis even in the setting of advanced or terminal rheumatic heart disease.

We have mentioned the blood pressure a number of times. Is this very helpful? In many types of heart disease in the terminal stages one may note hypotension. It may be seen in mitral stenosis, in patients with arteriosclerotic heart disease, in instances of myocarditis. In fact it may be seen in the terminal stages of practically all forms of heart disease except, as I mentioned previously, in the terminal phases of hypertensive cardiovascular disease where I would not expect to observe such low pressures for as long a period.

Fibrillation

Is the auricular fibrillation of any value in differential diagnosis? I should say it would be of definite value in excluding mitral stenosis. Although only about 50% of patients with rheumatic mitral stenosis have auricular fibrillation at death in one of the reported series, if one takes patients with mitral stenosis above the age of 60, fully 80% will have auricular fibrillation at death. If normal sinus rhythm had been present it would have been of value in the differentiation or exclusion of mitral stenosis. Even in syphilitic aortic insufficiency approximately 10% of patients will have auricular fibrillation in the course of the disease. In patients with aortic stenosis, between 15% and 25% will have auricular fibrillation at some point in the course. The incidence of auricular fibrillation is higher in patients with thyrotoxic

heart disease and in patients with advanced hypertensive and arteriosclerotic heart disease.

Aortic stenosis

Is there any type of valvular heart disease compatible with this course in which our diagnostic acumen is unusually poor? Yes, there certainly is and this is calcific aortic stenosis. Calcific aortic stenosis is a disease largely of men—it is approximately three times more common in men than women—in the period between the fifties and the seventies. There is good reason to believe that most instances are rheumatic in origin. We may find concurrent disease of the mitral and tricuspid valves, or it may occur as an isolated instance of pure aortic stenosis. The age of this patient is consistent. The rapid course from the time of onset of dyspnea to death is the usual story. Most patients live less than two years from the onset of heart failure. This patient died nine months after the onset of failure.

The cardiac contour on x-ray and EKG are compatible. In aortic stenosis we may find classical left ventricular hypertrophy in the EKG but a considerable number of patients have exactly the electrocardiographic form that we see in this patient.

The blood pressure is the classical blood pressure noted in patients with aortic stenosis. In the diagnosis of aortic stenosis the blood pressure is not a very useful sign unless it is this classical form. More than half the patients have blood pressures that are normal or elevated.

The aortic second sound was of less intensity than the pulmonic second sound. This is not of resounding diagnostic value, since in patients with aortic stenosis only about 50% have an absent aortic second sound or one that is of less intensity than the pulmonic second sound. It may be noted that the physical signs in aortic stenosis are quite variable.

Syncope has been mentioned once casually in this protocol. This is a common manifestation of the aortic stenosis. Ten to fifteen percent of the patients have syncope at some time in the course of the disease. On the other hand, patients with arteriosclerotic heart disease may develop complete heart block with syncope.

Murmur

But no "aortic" murmur was described in this patient. Does this not exclude the possibility

of aortic stenosis? We recall the classical signs of aortic stenosis —a long, rough systolic murmur, often with some accentuation in mid-systole, transmitted to the neck vessels, with a palpable thrill, and an aortic second sound that is absent. The classical pulse is small and slow. However, if we wait for the development of all of these signs, I am certain we would miss at least 50% of the instances of aortic stenosis. For example, the blood pressure is of the type described here in less than half the patients. Thrills are palpable in only about a quarter to a third of the patients with aortic stenosis. The classical murmur is found in no more than 60% to 70% of the patients. Actually, in a series of patients reported by Ellis and Bergeron, 10% of the patients with pure aortic stenosis had no audible murmur over the base of the heart and in this group three of the patients had "severe" aortic stenosis at autopsy. Further, it is known that the murmur of aortic stenosis may change markedly with the development of congestive failure. One may observe a classical murmur of the type described early in the course of the disease and subsequently as congestive failure develops, the murmur may decrease in intensity or even disappear.

How can we make the diagnosis of aortic stenosis in the absence of the classical signs as previously described? We should remember that this is a very deceptive valvular lesion. Calcification of the valve on fluoroscopy or regular x-ray films is very helpful, but unfortunately may not be detected even when extensive calcification is present at postmortem examination. At autopsy in patients beyond the age of 40, practically all have some calcification of the valve when isolated aortic stenosis is present. In some clinics tomography or planigraphic study has resulted in a very high detection of calcification.

Brachial arterial pulse curves would be diagnostic in most patients if recorded because of the characteristic plateau and anacrotic character of the pulse. I do not think that the evidence in this patient which has been presented today is sufficient for one to be secure in the diagnosis of calcific aortic stenosis.

Most likely

I mentioned earlier that it is possible for primary amyloidosis to simulate this story or be the cause of a clinical course such as we have heard. Idiopathic hypertrophy or "myocarditis" could

account for such a course. Nevertheless, calcific aortic stenosis, even without a classical murmur, must be more frequent than primary amyloidosis with cardiac involvement but without extracardiac disease. Therefore, on this statistical basis, I would place calcific aortic stenosis as the most likely possibility in this patient.

What complicating or concurrent disease was present terminally? First there is mention in the protocol of a stone of some kind, calcification overlying the right kidney. A gallbladder series was attempted but was not successful. I suspect that it was thought that this represented a gallstone.

Radiologist: There is a calcific density overlying the right kidney. However, on other views we observe that it is clearly not within the kidney. It has an appearance typical of a large gallstone, perhaps a calcification of the gallbladder.

Dr. Luckey: We don't have definite proof of this but on the basis of this account, I think one would feel justified in assuming that the patient does have cholelithiasis. This has been a "silent stone" without any effect on the course of this illness as far as can be determined.

In addition, there is evidence of calcification of the abdominal aorta. One would expect some evidence of vascular disease in a patient in this age group in our population. Does the presence of atherosclerosis of the abdominal aorta mean that the patient has significant coronary atherosclerosis as well? This does not mean that the patient has significant coronary atherosclerosis since atherosclerosis is commonly "spotty" in distribution. However, I would expect that we would find some coronary atherosclerosis in a woman of 69. The fact that we find some coronary atherosclerosis in no way means that this contributed to the clinical course that we have seen in this patient. In fact, one might see exactly the same amount of coronary atherosclerosis in a patient without evidence of cardiac hypertrophy of cardiac disease. I am certain that coronary atherosclerosis of moderate degree has deceived us many times in clinical-pathological correlations of heart disease of unknown cause.

Finally, repeatedly in the course of this patient, particularly during the second admission, an area of pulmonary infiltration has been mentioned. On the third admission chest pain was present and examination of the chest showed a pleural effusion but no

area of pulmonary infiltration. Then on the final admission the patient had an area of pulmonary infiltration in the left chest with increasing rales and signs of unilateral pulmonary disease out of proportion to the heart failure that was present.

Infection or infarction

Was this repeated infection in this patient or were these episodes of pulmonary infarction due to emboli? We have great difficulty in differentiating pneumonitis from pulmonary infarction in patients with chronic heart disease of all types. We should be very suspicious of infarction in any patient with chronic heart disease with an arrhythmia who reports repeated episodes of "pneumonia" in the past few years. It is quite likely that a considerable number of these instances are pulmonary infarction and not pneumonia.

This patient had venous disease of the lower extremities in the past. Heart failure with its slow flow of blood, predisposes in this setting to thrombosis and embolism. Certainly during the last admission when a new haziness appeared at the left base on x-ray, and pain was felt in the left upper abdomen, it was most suggestive of an embolic episode. In the absence of evidence of infection, I believe that each of these episodes was pulmonary infarction.

Now tell us about these x-rays in sequence.

Radiologist: On her second admission, the x-ray showed a marked increase in the amount of pleural effusion bilaterally plus a small infiltration in the second interspace, which subsequently cleared during antibiotic therapy. During the second admission an angiocardiogram was made by Dr. Steinberg. Unfortunately this is not entirely satisfactory. The main reason is the large size of the heart and bilateral pleural densities, which obscure the cardiac borders. We cannot say for certain that there is no pericardial effusion. However, we can say that the pulmonary arteries bilaterally are larger than commonly seen. The aorta is not larger than we usually see.

On the third admission there has been little change except that the heart has become larger. During the fourth admission and the last admission, the heart is markedly enlarged. There are large bilateral pleural effusions and the possibility of underlying pneumonitis or infarction cannot be ruled out radiographically.

Dr. Luckey: In this plate it

looks as if you can see enough of the right border of the heart to say there is no significant pericardial effusion.

Radiologist: There is no large amount of pericardial effusion.

Dr. Luckey: It would be my opinion that these episodes of chest pain, pulmonary infiltration with only slight fever, with no striking constitutional evidence of infection in a patient with congestive heart failure and auricular fibrillation are probably due to emboli, in this instance pulmonary emboli arising from the thromboses in the peripheral veins, rather than from the right heart.

In the last episode the patient had left upper quadrant abdominal pain, worse with breathing. No further account is given to help us in the differential diagnosis of this pain. It is entirely compatible with either a splenic infarct or a pulmonary infarct of the left lower lung area with diaphragmatic irritation.

In summary, although a definite diagnosis is not possible from the evidence we have, I am very suspicious of the possibility of calcific aortic stenosis as the cause of the heart disease, with enlargement of the heart, auricular fibrillation, and chronic congestive failure; second, repeated pulmonary infarction secondary to emboli probably from thrombi in the peripheral veins; and finally, a splenic infarct or possibly another pulmonary infarct as the terminal episode. If a splenic infarct occurred, the embolus must have come from the left heart. Cholelithiasis and arteriosclerosis of the abdominal aorta are concurrent, but essentially unrelated processes.

Is there further discussion of this interesting problem?

Doctor: I was curious about the remarkably low serum cholesterol.

Dr. Luckey: At the time this was determined in our laboratory the lower limits which were considered normal were 150. In the absence of diabetes, a cholesterol of 127 would make extensive atherosclerosis unlikely although we know she has arteriosclerosis of the abdominal aorta with calcification. I don't know how one can account for this low cholesterol. We see this in hyperthyroidism. She certainly had nothing to suggest hyperthyroidism.

Dr. E. Tolstoi: I notice on the third admission a perforated septum was detected but was not mentioned again. Do you attach any significance to that?

Dr. Luckey: I have not. In the past we have emphasized syphilis

as a cause of perforated nasal septa. The great majority of perforated septa are due to trauma and infection. Plucking of hairs is the most common cause of such infection.

Dr. Tolstoi: I have seen perforated nasal septa in lupus and blood dyscrasias, too.

Dr. Luckey: I would not personally pay much attention to it as a differential point.*

Doctor: I am very impressed by these very minor alterations of the EKG in this setting. I wonder whether these alterations are not useful in differential diagnosis.

Dr. Luckey: They may be due to pulmonary infarction.

Doctor: I wonder if it does not suggest that the lady has primary pulmonary disease due to multiple embolization.

Dr. Luckey: With what kind of underlying heart disease?

Doctor: There need be no underlying heart disease. The varicose venous disease may be the only vascular disorder, precipitating the kind of course observed in this patient.

Dr. Luckey: Conceivably, but I would think it unlikely as the cause of this entire course. I think that you are quite right that the EKG changes could be an indication of pulmonary infarction.

Doctor: Was consideration given to an inter-auricular septal defect?

Dr. Luckey: I did not give any consideration to it. There is nothing to suggest an intra-cardial shunt. The murmur that is noted is not prominent. There is no evidence of engorgement of the pulmonary hilar shadows such as you see in patients with this defect. Further, the age of the patient would be against that as the diagnosis.

Are there other comments or questions?

Doctor: How often do you get evidence of right-sided heart failure with primary aortic stenosis?

Dr. Luckey: This is not uncommon in the late stages of failure due to aortic disease. I suspect this lady had failure longer than she reports. It is described as sudden in onset but many patients with aortic stenosis, with compensation for a long period, will deteriorate rapidly over the course of a few weeks. Right-sided failure in this setting has led to the consideration of right

**(Addendum: Since this exercise the discussant has seen one additional case in which a perforated nasal septum was the only extracardiac manifestation of the process causing this patient's heart disease. E.H.L.)*

heart obstruction due to a bulging hypertrophied interventricular septum (the Bernheim syndrome).

Doctor: There is a good deal of dispute about the validity of this concept.

Dr. Luckey: Dr. Kidd will describe the findings on post-mortem examination.

Dr. John G. Kidd: The anatomical findings bear out the clinical indications that the signs and symptoms resulted from disturbances in the circulatory system, and they allow one to define the responsible disease process and to choose between the alternative diagnoses that have been considered.

The anatomical signs of heart failure were clearly manifest. In addition to the pitting edema of the feet and legs and other signs that had been noted clinically, there were multiple serous effusions—about 800 cc of straw-colored fluid in the left pleural cavity, 100 cc in the right, and 50 cc in the pericardial sac. The liver, although not greatly enlarged or increased in mass, had the typical nutmeg appearance that characterizes chronic passive hyperemia, and under the microscope it showed an immense number of red blood cells distending all the hepatic sinusoids and a very considerable pressure or anoxic atrophy of the hepatic parenchymal cells around the central veins.

I shall describe later the myocardial disease that brought about the heart failure, and will deal now with certain manifestations of thromboembolism which were quite conspicuous in this case.

There were organized thrombi, measuring up to 2.5 cm across, attached to the walls of both auricular appendages. In this relation you will recall that the auricles had been fibrillating during the last three months of the patient's life. Portions of the thrombus must have broken off and traveled as emboli to both rami of the pulmonary arteries during this time, for at postmortem examination quite large, gray adherent thrombi were found occluding most of the branches of the right pulmonary artery and the ramus supplying the posterior segment of the left pulmonary artery also.

Practically the whole of the right lower lobe was infarcted, and a firm, red infarct, 5 cm across, was present in the middle lobe as well. The left lung was partly collapsed, hyperemic, subcrepitant throughout.

At least one embolus must have taken origin from the mural

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thrombus in the left auricular appendage also, and traveled by way of the aorta to lodge in the left iliac artery near its point of origin. For at post-mortem examination, this vessel was completely occluded for a distance of several centimeters by a gray organized thrombus which extended upwards into the aorta almost to the level of the renal arteries and downwards into the right iliac artery. The propagating portions of this thrombus were grayish-red and obviously less well-organized than the thrombus which completely occluded the left iliac artery. These occlusions show plainly, it seems to me, why the femoral pulsations could not be felt during life. It is obvious that they had been present for some months.

The shadows in the x-ray films which were noted in the area of the right kidney resulted from 3 facetted, pigmented gall stones, the largest measuring almost 3 cm across. Microscopic examination showed that there was fibrous thickening of the wall of the gall bladder together with an infiltration by some chronic inflammatory cells.

The heart was the seat of the disease process that brought about the patient's death. As you may observe, the heart was greatly enlarged, being almost twice normal size. It weighed 660 gm. The wall of the left ventricle was greatly thickened and measured 23 mm across at the base. The pericardium was wholly unchanged. So, too, the large coronary arteries were essentially normal, being everywhere patent and having only a few focal atheromatous thickenings which did not notably diminish the caliber of the vessels. There were no septal defects and all the valves of the heart were unchanged, there being no sign whatever of aortic stenosis.

Amyloid

In the absence of valvular or septal defects, or arterio-venous aneurysms, the commonest cause of dilatation and hypertrophy of the heart with failure is, of course, hypertension. Yet, this patient had been carefully studied over many months, and numerous blood pressure readings had shown beyond doubt that the patient was not hypertensive. Hence, the prosector, Dr. Browne, scrutinized the myocardium with special interest. He noted an abnormality which is quite significant and which you can see—namely, that the myocardium is quite firm, its cut edge being sharp. Note how the organ maintains its form and contrasts

sharply with the more or less flabby specimens which we usually exhibit at these conferences. I can imagine that Dr. Browne anticipated that he would find upon microscopic examination of the heart either one of two conditions—namely, the so-called isolated myocarditis of Fiedler or amyloidosis.

Upon microscopic study, there was no sign anywhere of myocarditis. Neither was there any noteworthy scarring of the myocardium. Instead, as you can see from the photomicrograph, many of the myocardial fibers are literally encased in amyloid and largely or completely atrophic, while others, with less amyloid about them, are greatly hypertrophied. Here, for example, one can see the amyloid, selectively stained with congo red, deposited in sarcolemmal sheaths throughout the microscopic field and greatly thickening these structures, while the myofibers within are shrunken and devoid of cross-striations—indeed, absent here and there.

Amyloid can be seen also in the walls of most of the small arteries of the myocardium. For example, we see in this microscopic field four such vessels neatly arrayed; all have walls that are two or three times as thick as they should be, with greatly reduced lumina. And here is a larger artery in which one can see that the media has been largely replaced by homogeneous, pink-staining material that greatly diminishes the lumen of the vessel. With the congo red, as we see in the next slide, this material stains more or less selectively and has the morphological features of amyloid.

In this slide, one can see that the amyloid was not confined to the blood vessels and interstitium of the heart. Here, for example, are two interlobular arteries of the pancreas in which large depositions of amyloid can be seen, while the pancreatic acini round about are atrophic. Many of the smaller arteries in the liver, kidneys, lungs, thyroid, and adrenal showed similar changes, though the parenchymal alterations in these organs were minimal.

Here we see a single glomerulus of the kidney. Note that it is devoid of amyloid. This proved true of nearly all other glomeruli examined in two sections from each kidney. Obviously, the amyloidosis did not conspicuously involve the glomeruli. Furthermore, amyloid was not present in either the Malpighian bodies of the spleen or in the interstitium of the liver.

These observations deserve consideration together with the fact that there was no recognizable predisposing "cause"—such as fibrocaseous tuberculosis or chronic osteomyelitis or multiple myelomatosis—for amyloidosis in this case. The widespread deposition of amyloid in blood vessels, especially in those of the heart, noted in this case, is precisely that which has been repeatedly described as characterizing the so-called primary generalized form of amyloidosis, while the absence of a predisposing disease, the absence of alterations in serum protein levels, and the fact that amyloid was not present in the renal glomeruli or in the Malpighian bodies of the spleen, all weigh against the supposition that this might be a case of so-called secondary amyloidosis, as first described by Rokitansky in 1842. In this relation also the observation deserves mention that in so-called secondary amyloidosis the myocardium is seldom altered sufficiently to bring about heart failure.

Considered together, the findings in this case provide ample justification, it seems to us, for these anatomical diagnoses:

Primary generalized amyloidosis with extensive involvement of the blood vessels and interstitium of the heart and anatomical signs of heart failure.

Thrombo-embolism with mural thrombi in the right and left auricular appendages, emboli in both pulmonary arteries with infarcts in the right lung, and emboli in both iliac arteries and in the lower abdominal aorta.

Although we can sometimes make a distinction between the so-called primary and secondary forms of amyloidosis—as we have done in this case—I should point out, as Symmers has recently done (*J. Clin. Path.* 1956, *9*:187, 212), that this distinction cannot be made wholly upon anatomical findings but depends largely upon the presence or absence of a recognizable predisposing cause. Furthermore, although we can sometimes recognize clinically or on postmortem examination that amyloidosis has led to intractable heart failure, as it did in this case, I think we should be pretentious if we imagined that our knowledge of amyloidosis as a disease process is anything more than superficial. For actually we have only a meager understanding of its pathogenesis, while knowing next to nothing of its cause, and we are wholly devoid of means for curing it.

Dr. Luckey: I would like to

emphasize the fact that the clinical picture observed in this patient was really indistinguishable except by guessing on a statistical basis. It could have been due to the "big heart syndrome", primary amyloidosis, or aortic stenosis. It is clear that a statistical basis for diagnosis is unreliable when a single patient is under consideration.

In an article in the *British Heart Journal* about a year and one-half ago, five cases of primary amyloidosis were diagnosed at postmortem examination. None had gross extra-cardiac manifestations. In three of these patients, hypotension of the type described here was observed.

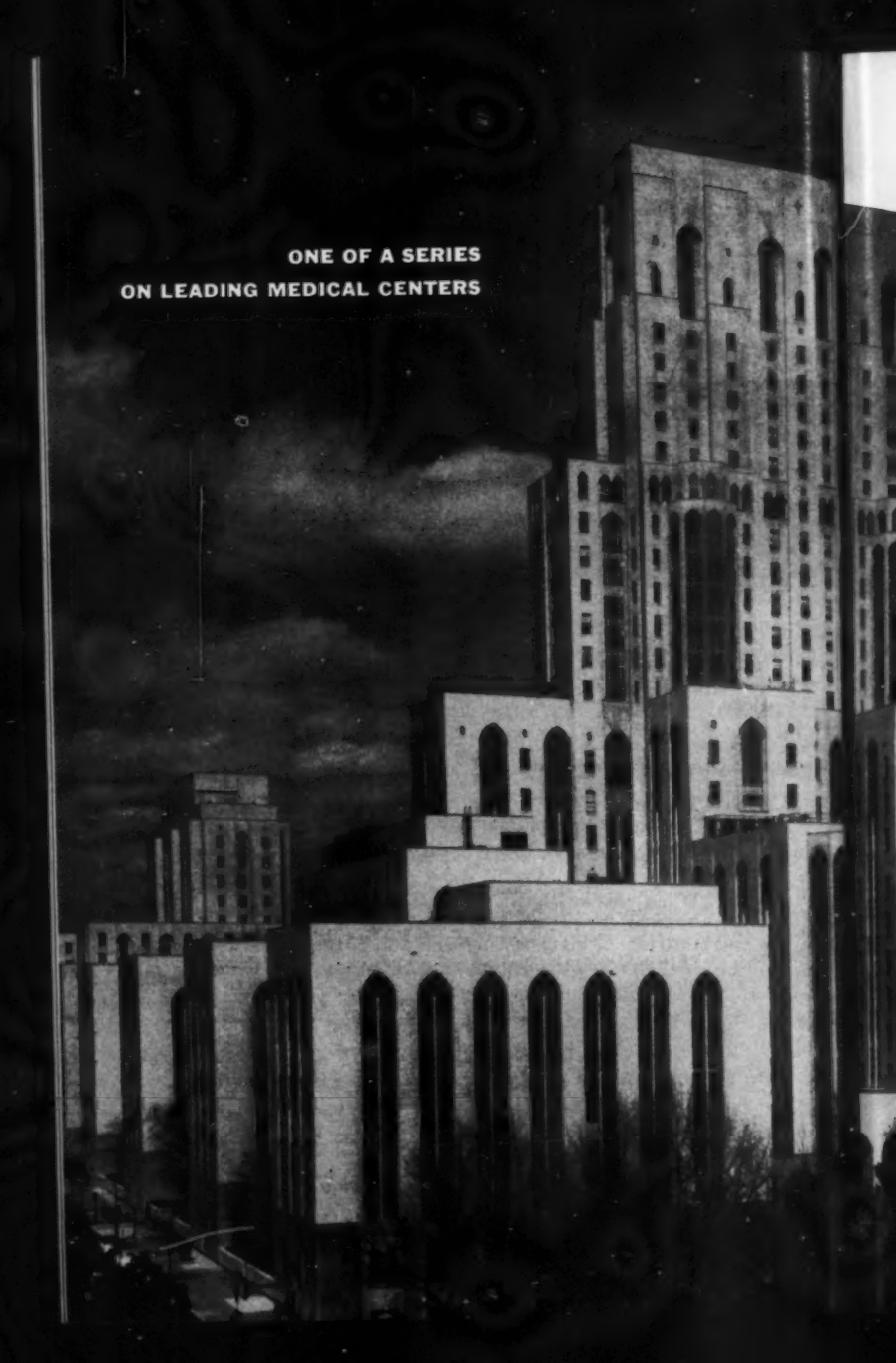
I am forced to conclude that, for the present, cardiac disease due to primary amyloidosis in the absence of extra-cardiac manifestations detectable on clinical or laboratory examination must remain a diagnosis to be made by the pathologist.

NONTENSE

Recently one of my patients on the psychiatric ward approached the head nurse with a whispered request for a 24-hour outside pass.

When asked why he wanted to leave the hospital, the patient hesitated, looked around furtively at his fellow patients and confided: "My horoscope tells me to avoid tense people today."

JOSE J. LLINAS, M. D.


ONE OF A SERIES
ON LEADING MEDICAL CENTERS

**One of the first hospitals in the nation,
New York Hospital,
in affiliation with
Cornell University Medical College,
is an established leader
in medical teaching and research.**

New York Hospital
Cornell Medical Center

By Royal Charter, granted on June 13, 1771, in the reign of King George III of England, The Society of the New York Hospital was formed and New York Hospital was established. It was the first hospital to be erected in New York City and the second in the North American Colonies.

The concept of a general hospital as a benevolent institution for the care of the sick without discrimination as to race or rank, for the study of medical problems, for prevention of disease, and for teaching and training was broadly outlined by Dr. Samuel Bard in an address in 1769. The Royal Charter was developed on the basis of these ideas. During

the past 187 years of its existence, New York Hospital, a voluntary, nonprofit hospital, has grown in size and complexity, while advancing the founding concept of care of the sick, teaching, research, and preventive medicine.

The first location of the Hospital was in lower New York City on Broadway between what are now Duane and Worth Streets. In 1877 it was moved to a newly erected building on West 15th and West 16th Streets near Fifth Avenue. In September 1932, it was moved to its present situation, East 68th Street and East River Drive. With Cornell University Medical College and Cornell University-New York Hospital School of Nursing, the hospital occupies 15 buildings in three city blocks of the New York Hospital-Cornell Medical Center.

A New York Hospital OR team in action with resident surgeons as the operators.

Governors

The Hospital is operated by The Society of the New York Hospital through a board of governors composed of 26 members who serve without pay. This board formulates policies and makes all final decisions. There are committees of the board of governors which deal with executive matters, finances, administrative affairs, staff appointments and certain medical professional activities.

Professional matters come to the board of governors chiefly through a medical board composed of the heads of the clinical departments and other medical representatives.

Administrative matters are handled mainly through the secretary-treasurer of the society when corporate action is involv-

New York Hospital's professional staff is composed of 765 attending physicians, 40 interns and 160 residents and assistant residents.

As a joint effort in patient care, hospital and public health nurses, nutritionist, social wo[illegible]ent and

ed, and through the hospital director in the management of the hospital.

New York Hospital includes a large number of clinical departments and divisions. The chief departments are medicine, obstetrics and gynecology, pediatrics, psychiatry, radiology, surgery and anesthesiology. There is a large outpatient department, and services for ambulatory patients covering the range from the care of the indigent to the Vincent Astor Diagnostic Service for those who can pay the full charge for diagnostic study.

The services in orthopedics and rheumatic diseases are performed through The Society's affiliate, The Hospital for Special Surgery.

The Society operates two large psychiatric services. One is the Payne Whitney Psychiatric Clinic at the site of the Center in New York. The other is the former Bloomingdale Hospital, now the New York Hospital-Westchester Division (White Plains, N. Y.). This is the continuation of original interest of New York Hospital in psychiatry, which began at the Hospital's inception. The administrative side of the Hospital is organized into departments and divisions.

Staff

Indicative of the scope of the Center's activities, the professional staff includes upwards of 765 attending physicians. In addition, 40 interns and 159 assistant residents and residents are in training at the hospital.

Nursing care is provided by a staff of 650 graduate nurses. Nursing education is provided for 250 students. Training of an auxiliary nursing staff for 500 orderlies, nursing aides and attendants is provided through the Nursing Service.

ent and therapists combine talents.

The total number of beds in the main hospital is 1,206 (including bassinets and the beds for psychiatry in the Payne Whitney Clinic). The addition of the beds for psychiatry at the Westchester Division brings the total up to 1,556. The number of patients admitted in a given year is about 31,000, and total patient days, about 462,000. More than 44,000 persons make approximately 220,000 visits to the 86 clinics of the outpatient department annually.

Through the Joint Administrative Board, and through hundreds of personal and department associations the hospital's activities are integrated in various degrees with teaching of medical students and nurses, postgraduate training of members of the resident professional house staff, training of dietitians, radiographers and other auxiliary personnel, and with the large programs of research of the departments. In addition, through its relationships with organizations and agencies outside of the institution, the hospital endeavors as best it can to serve its community, its country, and the international interests of medicine and public health.

University affiliation

In response to the petition of a group of leaders of the medical profession in New York and the generous offer of support given by Colonel Oliver Hazard Payne, the Board of Trustees of Cornell University established the Cornell University Medical College in New York City, April 14, 1898. Colonel Payne provided funds for the erection of the original buildings of the Medical College located at 28th Street and First Avenue. He also gave funds for the annual support and later for the endowment of the institution.

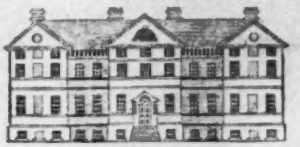
The Medical College remained at its original location until 1932 when it moved into buildings constructed for occupancy by the College and New York Hospital, at the present site of the Medical Center.

All department heads are on full-time status; they do not engage in practice or other activities for personal remuneration. Their time is devoted to teaching,

Nº. I.

Charity Extended To All.

STATE of the *New-York Hospital* for the Year 1797.



GOVERNORS.

GERARD WALTON, *President.*
MATTHEW CLARKSON, *Vice-President.*
JOHN MURRAY, *Treasurer.*
THOMAS EDDY, *Secretary.*

Peter Schermerhorn,
John Murray, jun.
William Edgar,
William Minturn,
Thomas Buchanan,
Robert Bowne,
John C. Kunzie,
Edmund Prior,

Moses Rogers,
John B. Coles,
Henry Haydock, jun.
Henry Rutgers,
John Thurston,
John I. Glover,
Thomas Franklin,
William T. Robinson,

James Kent,
Hugh Gaine,
William Jauncey,
Jacob De La Montagnie,
James Watson,
John Barrow.

PHYSICIANS.

John R. B. Rodgers,
Elihu H. Smith,

Samuel L. Mitchell,
David Hosack.

SURGEONS.

Richard Bayley,

Wright Post,
Richard S. Kissam,

Samuel Borrowe,
Valentine Seaman.

Adolph Lent, *Apothecary,*
Samuel Barnum, *House-Surgeon,*
William Hogsfleth, *Steward,*
Mary Smith, *Matron.*

THIS Institution was undertaken by private Subscriptions of the Inhabitants of NEW-YORK, in the Year 1770, and in Consequence of a Petition to the then Governor, by *Peter Middleton, John Jones,* and *Samuel Bard,* three respectable Physicians of this City, was incorporated by Charter on the 13th of the sixth Month, (June) 1771, under the Stile and Title of, *The Society of the Hospital in the City of New-York, in America.*

Animated

Reproduction of the first annual report of New York Hospital. *From the Edward W. C. Arnold Collection, Metropolitan Museum of Art.*

Account of the Number of Patients admitted in the New-York Hospital, from 31st January, 1797, to 31st January, 1798.

DISEASES.	Remaining 31st Jan. 1797.	Admitted from 31st Jan. '97, to 31st Jan. '98.	Total.	Cured.	Relieved.	Discharged by Fines.	Eloped and otherwise discharged.	Died.	Remaining 31st Jan. 1798.
Amenorhœa,	1	4	5	2			2		1
Atrophia,	1		1						1
Ascites,	1	15	16	9	3		1	2	1
Burns,	1	3	4	3					1
Cancers,	1	1	2	1	1				
Diarrhœa,	1	7	8	5	1				2
Febris Intermit.	3	37	40	27			3	2	1
Frozen Limbs,	12	19	31	13	2	5			10
Fractures,	5	16	21	9	3				9
Gonorrhœa,	1	6	7	3			2		2
Mania,	4	18	22	4	5	1	1	2	9
Melancholia,	1		1		1				
Ophthalmia,	1	5	6	3			1		2
Palfy,	1	2	3	1	2				
Phelm.	1		1	1					
Phthis Pulmon.	1	5	6		2	1		3	
Pneumonia,	17	48	59	24		2		13	20
Rachitis,	1		1	1					
Rheumatifm,	5	37	42	24	9		4	1	4
Schrophula,	2	3	5	3			1		1
Syphilis,	24	103	127	76	15	1	11	1	23
Tumor,	1	2	3	2					1
Ulcers,	21	68	89	39	10	1	13	3	23
Wounds,	5	13	18	15	2			1	2
Apoplexy,		2	2						
Anafarca,		6	6					5	1
Albuna,		1	1					1	
Colica,		2	2	1				1	
Cataract,		2	2	2					
Catarrh,		1	1						1
Dislocations,		2	2	2					
Dyfentery,		5	5	3	1			1	
Dyfpepfia,		5	5		1			2	2
Fiftula,		4	4	1	1			1	1
Gravel,		2	2	2					
Hemoptifis,		1	1	1					
Herpes,		2	2	2					
Hepatitis,		2	2	1			1		
Luxation,		9	9	9					
Lumbar Abfcefs,		2	2			1			
Sciatica,		1	1	1					
Scorbutus,		1	1				1		
Tinea Capitis,		1	1	1					
Typhus,		8	8	5	1			2	
White Swelling,		1	1						1
	106	472	578	296	60	12	41	57	112

RECAPITULATION.

Patients Remaining in the Hospital 31st January, 1797,		106
Admitted from the 31st January, 1797, to 31st January, 1798,		472
Discharged.—Cured,	296	
——— Relieved,	60	
——— Be Before,	12	
——— Difordered by and Eloped,	41	
——— Died,	57	
	466	
Remaining in the Hospital 31st January, 1798,		112

—Who were Natives of the following Places,—

America.	England.	Scotland.	Ireland.	France.	Germany.	Spain.	Ruffia.	Portugal.	Sweden.	Holland.	Denmark.	Italy.	Norway.	Africa.	Eaft-Indies.	Weft-Indies.	TOTAL.
240	57	25	165	9	20	8	2	1	7	11	3	3	3	8	8	8	578

Photo, courtesy Museum of The City of New York.

ABSTRACT *of the* ACCOUNTS *of the* NEW-YORK HOSPITAL, *being a Summary of the Receipts and Expenditures, from the 31ſt of the firſt Month,* 1797, *to the* 31ſt *of the firſt Month,* 1798.

Dr. *Cr.*

	£.	s.	d.		£.	s.	d.
To Balance due ſundry Perſons from laſt Year,	1420	12	3	By Caſh received for Pay Patients,	684	18	4
To Houſhold Expences, £259 17 4				By ditto for two Cows and a Calf,	15	0	0
To Servants Wages, 85 19 4				By ditto for Fat,	1	7	8
To Wine, Spirits, &c. 294 11 6				By ditto of *Gerard Bancker*, Treaſurer to the State,	4750	0	0
To Medicines, Sweet Oil, Limes, &c. 343 11 3				By ditto of *C. Miller*, Harbour-Maſter, for Fines, purſuant to an Act of the Legiſlature, paſſed in the Year 1796,	80	0	0
To Wood and Coals, 549 2 9				By ditto for 3 Years Intereſt on a Bond of the Corporation of the City of New-York,	60	0	0
To Books, &c. for the Library, 77 4 11				By Balance due to the Treaſurer, £1193 3 0			
To Sundries for Repairs, 573 1 0				By ditto due to ſundry Perſons, as per the Steward's Account, 172 11 7½			
To Expence of Funerals, 116 16 0							
	5500	4	1				
To Caſh paid the Executors of *Lawrence Embree*, for Timber, &c.	36	4	3		1365	14	7½
	£6957	07	1½		£6957	07	1½
To Balance per Contra,	1365	14	7½				

Photo, courtesy Museum of The City of New York.

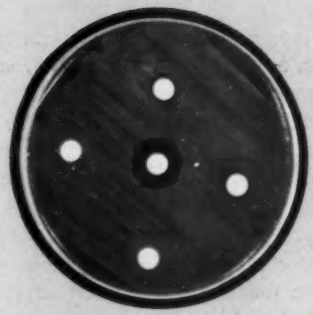
research, patient care in the clinical departments, and to intellectual and scientific interests directly connected with the college and its objectives.

In addition, there are staff members in nearly all grades holding part-time appointments through which they serve the college and related institutions.

Teaching and research departments of the college are anatomy, bacteriology and immunology, biochemistry, medicine, obstetrics and gynecology, pathology, pediatrics, pharmacology, physiology and biophysics, psychiatry, public health and preventive medicine, radiology and surgery. The total number of students enrolled has averaged approximately 340, about 80 to 85 in each of the four classes. Students come

The list of conferences on page 110 shows the scope and variety of specialty material offered within the department of medicine. Services other than medicine within the hospital also sponsor weekly conferences.

on the problem of antibiotic-resistant bacteria



A POINT OF VIEW IN '55 "At this time, it appears that the problem of antibiotic-resistant bacteria is the greatest fear in the future with chronic infections of the . . . urinary tract . . ."[1]

A POINT OF FACT IN '58 ". . . This prediction has proved to be correct for both gram-positive and gram-negative organisms."[2]

. . . WITH ONE NOTABLE EXCEPTION ". . . studies indicate that microorganisms, in vitro and in vivo, do not appear to develop resistance to FURADANTIN."[3]

for acute and chronic urinary tract infections

FURADANTIN®

brand of nitrofurantoin

AVERAGE FURADANTIN DOSAGE: In acute, complicated or refractory cases and in chronic infections—100 mg. q.i.d., with meals and with food or milk on retiring.

REFERENCES: 1. Flippin, H. F.: Virginia M. Month. 82:435, 1955. 2. Caswell, H. T. et al.: Surg. Gyn. Obst. 106:1, 1958. 3. Nesbitt, R. E. L. Jr., and Young, J. E.: Obst. Gyn., N. Y. 10:89, 1957.

in 7 years—negligible development of bacterial resistance with FURADANTIN

NITROFURANS . . . a *new* class of antimicrobials . . . 
neither antibiotics nor sulfonamides

EATON LABORATORIES, NORWICH, NEW YORK

from all parts of the United States, and occasionally from foreign countries.

The college is administered by the dean and his associates in accordance with policies and decisions made by Cornell University, an administrative board and the executive faculty. The executive faculty is composed of the heads of the departments and three administrative officers.

Facilities available to the college are those of its own buildings and laboratories and library, New York Hospital, and certain facilities at other hospitals, including Bellevue Hospital and Memorial Hospital for Cancer and Allied Diseases. Most of the clinical teaching of medical students is done at New York Hospital, but other services, particularly those at Bellevue Hospital, are used increasingly.

Activities in the college are associated intimately with those of New York Hospital. A considerable part of this close relationship results from the joint sharing of expenses and appointments between the college and hospital. The total integrated effort, however, is the outcome of

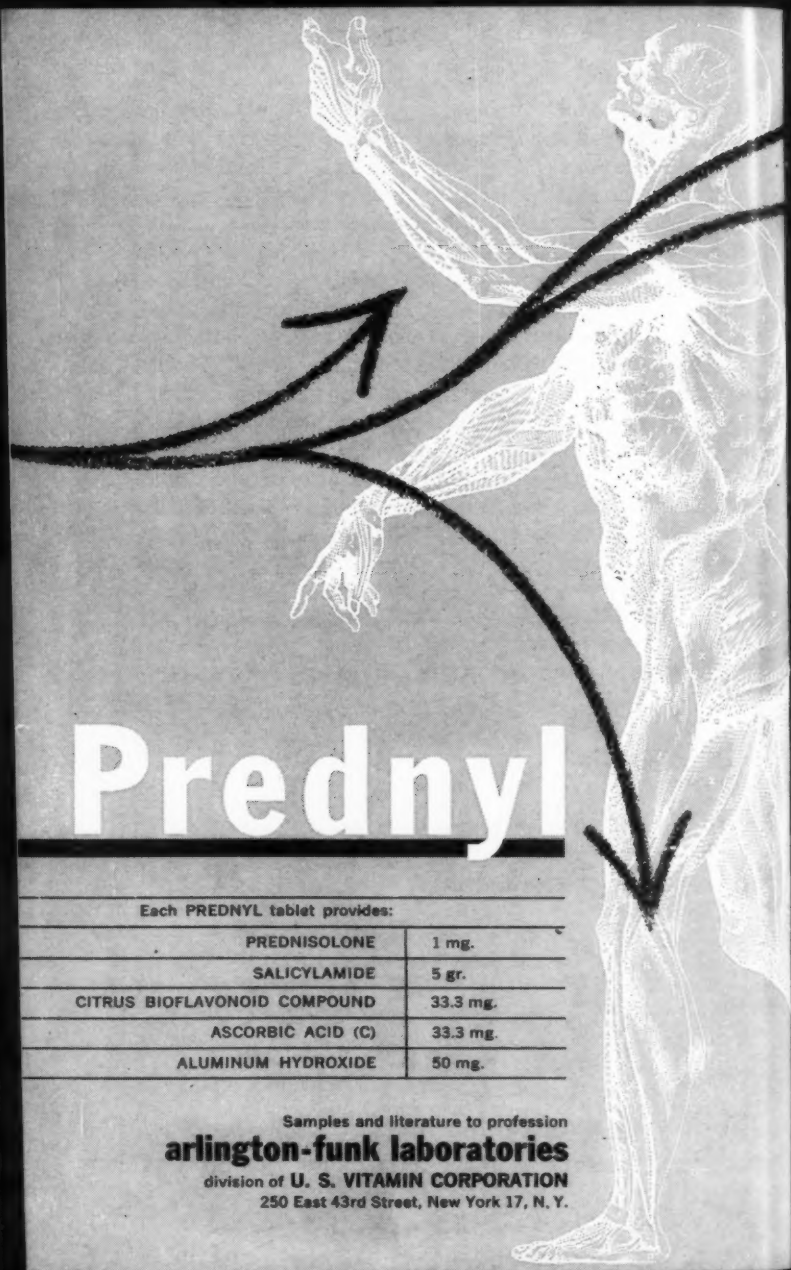
NEW YORK HOSPITAL MEDICAL CONFERENCES

MONDAY	Cardiovascular Conference	12:00- 1:00
	Clinical Pathological Conference	4:00- 5:00
TUESDAY	Endocrine Conference	12:00- 1:00
	Neurology Conference	4:00- 5:00
WEDNESDAY	Gastrointestinal Conference	12:00- 1:00
	Conference on Vascular Diseases	4:15- 5:15
THURSDAY	Medical Conference	10:00-11:30
	Conference on Health and Human Ecology	1:00- 2:00
	Hematology Conference	1:00- 2:00
	Neurology Conference	4:00- 5:00
FRIDAY	Dermatology Conference	1:00- 2:00
	Radiology Conference	3:00- 4:00
	Pulmonary Conference	4:00- 5:00

NEW YORK HOSPITAL—HOUSE STAFF QUOTA 1958-1959

DEPARTMENT	CHIEF OF SERVICE	INTERNS	ASSISTANT RESIDENTS	RESIDENTS	TOTAL
Anesthesiology	Joseph F. Artusio	None	6	6	12
Medicine	E. Hugh Luckey	18	25	2	45
Obstetrics-Gynecology	R. Gordon Douglas	None	17	5	22
Pathology	John G. Kidd	3	5	1	9
Pediatrics	Samuel Z. Levine	2	15	1	18
Psychiatry	Oskar Diethelm	None	13	2	15
Radiology	John A. Evans	None	15	6	21
(General) Surgery	Frank Glenn	16	24	6	46
Neurosurgery	Bronson S. Ray	None	1	1	2
Ophthalmology	John M. McLean	None	5	1	6
Oral Surgery (Dentistry)	George F. Egan, D.M.D.	2	—	1	3
Orthopedics*	T. Campbell Thompson	None	1	1	2
Otolaryngology	James A. Moore	None	3	1	4
Plastic Surgery	Herbert Conway	None	1	1	2
Urology	Victor F. Marshall	None	5	1	6
				Total	213

* The Services in orthopedics and rheumatic diseases are performed through the affiliated Hospital for Special Surgery. A residency program in orthopedics is offered by the Hospital for Special Surgery, 535 East 70th Street, New York City.



Prednyl

Each PREDNYL tablet provides:	
PREDNISOLONE	1 mg.
SALICYLAMIDE	5 gr.
CITRUS BIOFLAVONOID COMPOUND	33.3 mg.
ASCORBIC ACID (C)	33.3 mg.
ALUMINUM HYDROXIDE	50 mg.

Samples and literature to profession

arlington-funk laboratories

division of **U. S. VITAMIN CORPORATION**

250 East 43rd Street, New York 17, N. Y.

new, safer,
more comprehensive
anti-inflammatory,
antirheumatic,
analgesic

in rheumatoid arthritis, myositis, fibrositis, bursitis, and other inflammatory and rheumatoid conditions

PREDNYL affords prompt, dramatic relief from pain and muscle spasm, increased range of motion and often return to normal activity—because of . . .

3-way anti-inflammatory action: with potent prednisolone, water-soluble citrus bioflavonoid compound, salicylamide.

greater antirheumatic, analgesic effects: with less prednisolone and less salicylate than when either is given alone —minimizing risk of steroidism or salicylism.

protection: against steroid-induced capillary hemorrhage, gastric distress, vitamin C depletion.

dosage: Average, 1 to 3 PREDNYL tablets q.i.d., with gradually reduced dose to effective maintenance level. Bottles of 100 and 500.

voluntary loyalty to the medical center concept and the practical advantages derived from collaboration.

Recreation

Squash courts are available for the use of the resident and attending staff. In addition, a lounge equipped with pianos, television and billiards is provided within the House Staff quarters. City owned and operated tennis courts are located three blocks from the hospital.

Housing

House staff quarters are provided on six upper floors of the main hospital. In addition, the hospital owns a number of apartment buildings in the adjacent area. These apartments, both furnished and unfurnished, are available to members of the house staff and nursing personnel within the Center. A rental service is maintained and priority on apartments is given to members of the house staff.

Stipends and perquisites

Intern stipend is $1,270 a year; assistant resident from $1,520 to $2,270, and resident ranges from $2,520 to $2,820.

In addition to amounts shown above, the hospital provides or pays for living quarters for interns and assistant residents at the rate of $450 per annum and for residents at the rate of $630 per annum.

Uniforms and laundry are furnished free of charge. The stipend contains an allowance for meals; accordingly the individual house officer is responsible for purchasing his meals. The hospital operates 4 nonprofit cafeterias for the use of hospital personnel.

Each member of the house staff is provided a Blue Cross contract (Associated Hospital Service of New York) free of charge. Should the house officer wish to extend Blue Cross coverage to his family, the additional cost is deducted from his stipend. The hospital maintains a Personnel Health Service and also provides free ambulatory care to the house officer's family.

Malpractice

Members of the house staff are covered by a blanket malpractice policy maintained by the hospital. The individual house officer is therefore not expected to maintain an independent malpractice policy.

Religious facilities

There is an established chap-

FOR THE PREVENTION OF POSTPARTUM BREAST ENGORGEMENT, LACTATION AND PAIN

Vallestril®

(brand of methallenestril)

—avoids most withdrawal bleeding

—minimizes secondary breast symptoms and uterine subinvolution

—"... causes fewer gastrointestinal upsets[1] than does diethylstilbestrol."

Schneeberg and his associates[2] gave Vallestril to 198 patients with postpartum breast engorgement, pain and lactation. They reported: "The patients ... achieved over-all results ... somewhat better than those in patients receiving 3 mg. of diethylstilbestrol.... Untoward effects, even when large doses were used, were rare. The 'slight bleeding' recorded ... was probably of no significance and was doubtless no more than would have occurred in these individuals without therapy."

Napp, Goldfarb and Massell[3] conducted a controlled study in which 207 postpartum patients received Vallestril, 213 patients were given diethylstilbestrol and 193 patients did not receive hormone therapy. "The stilbestrol treated group showed a significantly greater incidence both of interim bleeding and of hypermenorrhea than did the control or the Vallestril treated groups."

These authors concluded that "Vallestril is a superior synthetic estrogen for the suppression of lactation. The low incidence of interim bleeding and of hypermenorrhea constitute a most important characteristic of the drug."

Only two 20-mg. tablets taken daily, for five days, suppress lactation and relieve engorgement and pain. Dosages for indications other than the suppression of lactation are given in Reference Manual No. 7. G. D. Searle & Co., Research in the Service of Medicine.

---

1. Council on Drugs: New and Nonofficial Drugs 1958. Methallenestril, Philadelphia, J. B. Lippincott Company, 1958, pp. 477-478.

2. Schneeberg, N. G.; Perczek, L.; Nodine, J. H., and Perloff, W. H.: Methallenestril, a New Synthetic Estrogen, J.A.M.A. 161:1062 (July 14) 1956.

3. Napp, E. E.; Goldfarb, A. F., and Massell, G.: The Parenteral Use of Methallenestril for the Suppression of Lactation. A New Approach, West. J. Surg. 64:492 (Sept.) 1956.

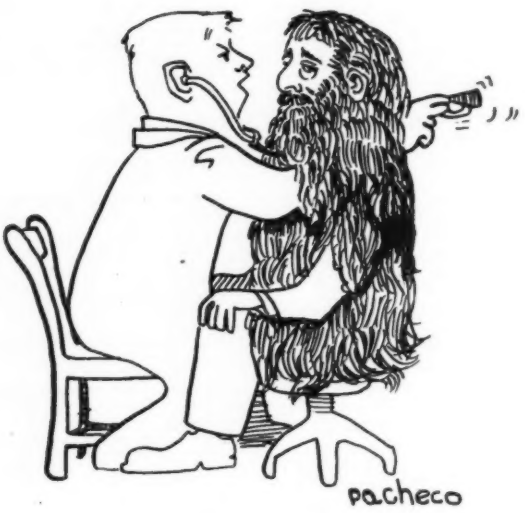
SEARLE

laincy service available to hospital patients and staff. A chapel in the main lobby of the hospital is provided for meditation and prayer. No services are held.

Library

The reading room of the library is situated on the second floor of the central group of laboratory buildings, directly over the entrance of the Medical College. Current journals are kept in racks around three sides of the room. The book stacks are directly behind and open to the reading room, extending down to the sub-basement with six floors of stacks. There are also a library seminar room and offices for the library staff.

The library contains about 70,000 volumes, largely made up of complete sets of important journals in the fields of clinical medicine and the medical sciences, in English, German and French. There are also selected collections of monographs and textbooks.



help normalize prothrombin time before surgery

"has a more prompt, more potent and more prolonged effect than the vitamin K analogues"*

MEPHYTON®

VITAMIN K_1

Reduce the hazard of hemorrhage due to hypoprothrombinemia during or after surgery: tonsillectomy, obstetrical and gynecological procedures, surgery of the newborn (especially prematures), neurosurgery, thoracic surgery, intestinal surgery, biliary tract surgery, rhinoplasty, surgery in any highly vascular area.

Especially indicated in patients with obstructive jaundice, or when prothrombin level is depressed following administration of anticoagulants, barbiturates, salicylates, antibiotics, sulfonamides, or phenylbutazone. Can also be used postoperatively to combat hemorrhage due to hypoprothrombinemia.

Dosage: Surgery—up to 50 mg. orally at least 24 hours preoperatively or up to 50 mg. intravenously at least 12 hours preoperatively to restore prothrombin to safer levels.

Supplied: Tablets, 5 mg., bottles of 100. Emulsion, each 1-cc. ampul contains 50 mg., boxes of 6 ampuls.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA

Mephyton is a trade-mark of MERCK & CO., INC.

*Council on Pharmacy and Chemistry: New and Nonofficial Remedies, Philadelphia, J. B. Lippincott Co., 1956, p. 505.

Henry N. Pratt, M.D.

Guest Editorial

Cutting Costs of Medical Care

Each month the chief residents of our eighteen clinical services at New York Hospital are my guests for lunch. This provides an opportunity to discuss topics of mutual interest. Among these has been the economic impact of medical advances on the cost of hospital care. In view of the interest expressed by our residents I propose to discuss this subject briefly.

Since the close of World War II, unprecedented changes have taken place in the hospitals of this country. Medical research has developed an ever increasing number of scientific procedures which have made possible dramatic advances in medical care. Because of the high cost of these procedures and the need of avoiding duplication of expensive equipment and services, hospitals have accepted the responsibility of providing them. In addition, hospitals have participated actively in the development of more comprehensive health care programs for the public benefit. They have, in fact, become the centers for community health services.

The economic impact of these advances is startling. In the twelve-year period, 1946 through 1957, the patient day cost in voluntary general and special hospitals for the entire United States increased by 161.5 percent. This is at a rate

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NECROSIS and SECONDARY INFECTION of decubitus ulcers ARE CONSTANT THREATS[1-5]

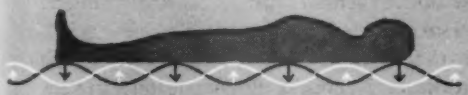
The Alternating Pressure Pad

"...a very effective measure"[4]

Eliminates decubitus dangers and discomfort

When debilitated bed- and chair-ridden patients cannot easily shift their weight, the resultant ischemia frequently produces decubitus ulcers.[1,3,5] These gangrenous lesions are painful, persistent, and prone to secondary infection.[3]

A simple, effective, and time-saving way of promoting local circulation in such patients is the use of the Alternating Pressure Pad. The APP unit is a special air mattress



with two series of air cells, alternately inflated and deflated every three minutes by automatic mechanical means, thereby constantly shifting the pressure points against the patient's skin. Local circulation is encouraged without the trouble and discomfort of turning the patient frequently.[1,4,6] The APP unit is guaranteed to be safe, simple, foolproof.

References cited: (1) Gardner, W. J.: J.A.M.A. 154:804, 1954. (2) Anderson, W. A. D.: Pathology, p. 99, St. Louis, C. V. Mosby Co., 1953. (3) Sutton, R. L.: Diseases of the skin, p. 704, St. Louis, C. V. Mosby Co., 1950. (4) Didisheim, J. W.: 330, in Conn, H. F., (ed.): Current Therapy, W. B. Saunders Co., Phila., 1957. (5) Davidoff, L. M.: 497, ibid. (6) Gardner, W. J. et al.: Arch. Phys. Med. Rehab. 578:580, Sept., 1954.

Thousands of APP units now in private and government hospitals

Units available for standard beds, respirators, wheel chairs. We will be pleased to demonstrate the APP unit in your office or hospital. No obligation, of course. The APP unit is available for use in hospitals and private homes on a rental basis.

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WASTING DISORDERS

"The alternating pressure pad is useful in the prevention as well as the treatment of decubitus ulcers.

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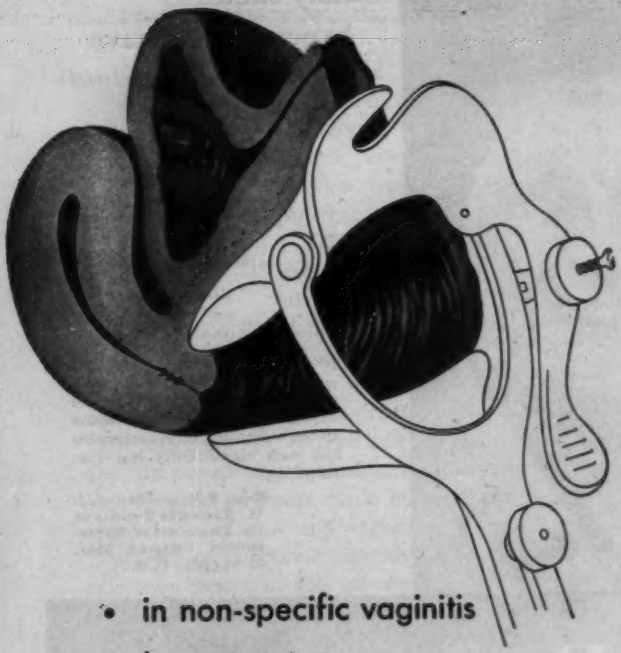
Director of The
New York Hospital

of increase of 13.5 percent per year, or more than 1 percent per month for the twelve-year period. For the second half of this period, 1951 through 1957, the increase was 48.2 percent or 8 percent per year.

The principal cause of this inexorable rise in hospital costs are those scientific advances which have made possible such giant strides in the improvement of medical care. These advances have resulted in increasing reliance on laboratory techniques in diagnosis and in therapy; increasing complexity of x-ray diagnosis; more extensive use of high voltage radiation in cancer therapy; the broadening field of surgical treatment as exemplified by the rapid advances made in heart and lung surgery; extensive use of new and expensive drugs, especially in the treatment of infections; development and use of new scientific approaches to the solution of medical problems such as radioisotopes and the artificial kidney; expansion of facilities and services for the rehabilitation of the chronically ill; establishment of home care programs; and increasing emphasis on the integration of psychiatric services with general hospital care. These are but a few of the developments that have been made possible by medical research and continuing efforts to improve health services. That they have been of incalculable benefit to mankind there can be no gainsaying; but the cost in dollars is high.

A cost study of fifty general hospitals, members of the United Hospital Fund in New York City, reveals the startling fact that during the same twelve-year period, 1946 through 1957, that segment of hospital cost concerned with these professional and technical services rose by 283 percent while the cost of hotel type service, which includes bed, preparation of food with meals served in bed, administration, plant operation, laundry, house-keeping and other services pro-



- in non-specific vaginitis
- in postpartum care
- after vaginal surgery

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vided by hotels, rose by less than 30 percent.

If hospital costs continue to rise in the future as they have in the past, and there is every reason to believe that they will do so, it is possible that the public will balk at the price. The only recourse will be some sort of insurance under the aegis of the Federal Government, a step we would all deplore.

What, then, can we as individuals do? We can and must provide our patients with the highest quality care of which we are capable, but we can also protect their pocketbooks through the practice of discrimination in the use of the vast array of professional and technical procedures available to us.

Dr. David P. Barr in the 1955 Frank Billings Memorial Lecture discussed the dangers of toxic and unfavorable actions of diagnostic and therapeutic measures. He concludes that his "choice of topic developed from an ever-growing conviction of the extent and variety of dangers intrinsic in the medical practice of today and from a desire to suggest that discriminating selection of measures may be more important than unreflective completeness. It is suggested that it may be as useful to the patient that his physician know when not to treat as when to treat and that the use of potentially dangerous agents for trivial or inconsequential complaints may not be justifiable. Only by such discipline and understanding may we, as physicians, avoid doing unnecessary harm and minimize the price we and our patients pay for modern management of disease."

Dr. Barr's suggestion that "discriminating selection of measures may be more important than unreflective completeness" applies with equal force to keeping the cost of medical care within the ability of the public to pay for it as to avoiding toxic and unfavorable reactions. The same discrimination should, of course, be practiced in the selection of diagnostic procedures, toxic or not. Such thoughtful consideration for the financial problems of our patients as well as their health problems will go far towards preventing the spread of government control to all our health services.

How to Equip the Urologist's Office

A survey of urologists now in practice reveals basic principles to guide you in your choice of equipment —and the price you pay. All agreed on one point: if you plan carefully, compare features and costs of similar items, you can save a considerable amount of money without sacrifice of essential equipment.

In furnishing offices for the practice of urology, two points should be considered at the outset.

First, the urology practice deals for the most part with adult patients, the majority being elderly.

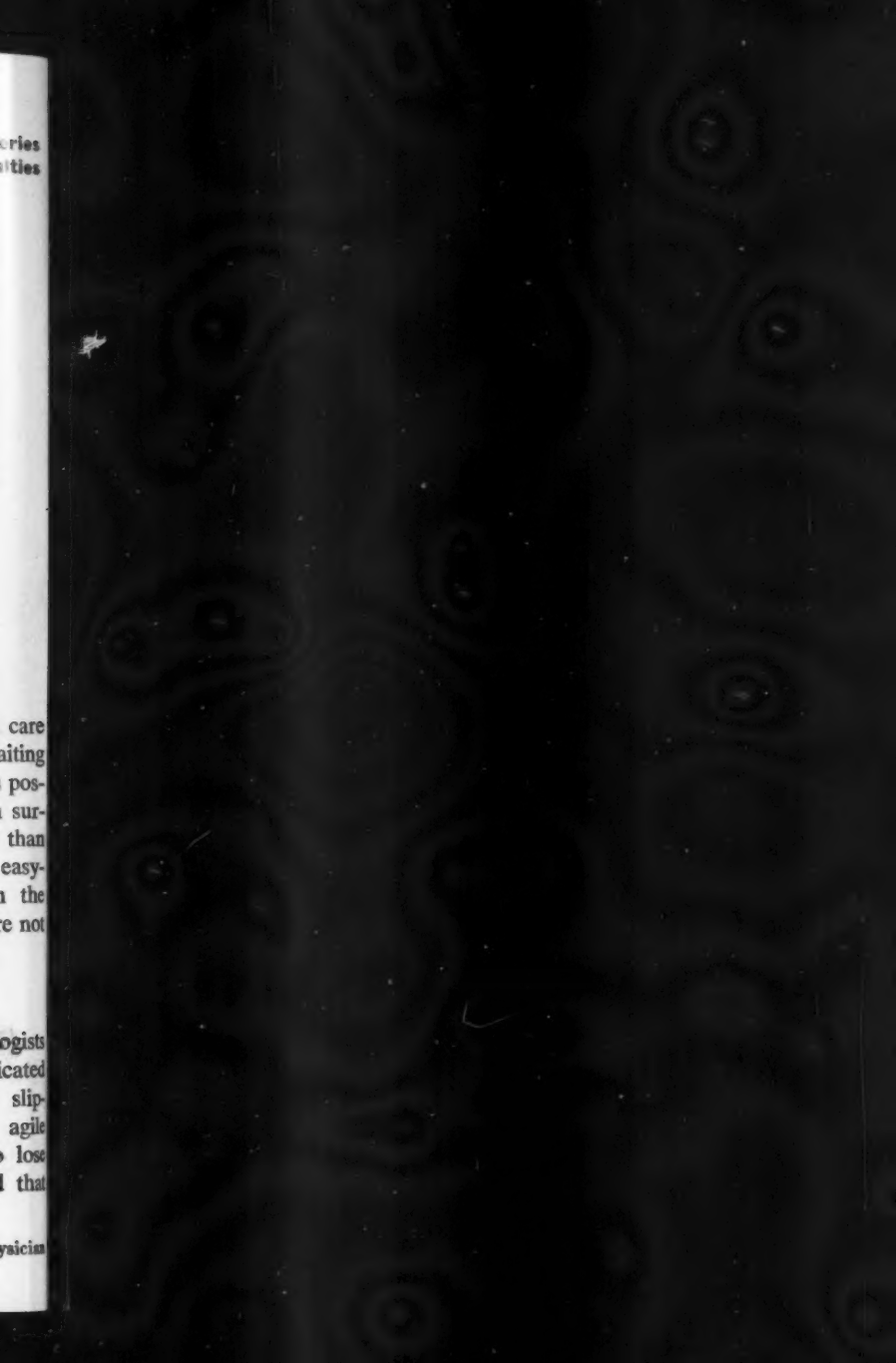
The second factor concerns a frequent complaint of the urology patient: incontinence. The latter, of course, indicates that the urologist's lavatory should be accessible from the waiting room.

Waiting room

Since the elderly adult is apt to be considerably less agile than, say persons in their thirties, care should be taken that the waiting room is as accident-proof as possible. For example, though surveys of specialists other than urologist's were in favor of easy-to-maintain tile flooring in the waiting room, urologists were not in agreement.

Floor covering

The majority of urologists questioned in the survey indicated that tile floors were more slippery; consequently the less agile patient was more likely to lose his footing. Most reported that



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—the remarkably efficient skeletal muscle relaxant, unique in chemical formulation, and outstanding for sustained action and relative freedom from adverse side effects.

PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:160, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Pharm. Assn., Sci. Ed. 46:274, 1957. 5. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 167:168, 1958. 7. Truitt, E. B., Jr., and Patterson, R. B., Proc. Soc. Exper. Biol. & Med. 93:622, 1957. 8. Truitt, E. B., Jr., Patterson, R. D., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:182, 1957.

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Robaxin Beneficial in 95.6% of Cases of Acute Skeletal Muscle Spasm[1, 2, 3, 4]

CONDITION	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
STUDY 1[1]					
Skeletal muscle spasm secondary to acute trauma	33	26	6	1	—
STUDY 2[2]		"pronounced"			
Herniated disc	39	25	13	—	1
Ligamentous strains	8	4	4	—	—
Torticollis	3	3	—	—	—
Whiplash injury	3	2	1	—	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—	—
STUDY 3[3]		"excellent"			
Herniated disc	8	6	2	—	—
Acute fibromyositis	8	8	—	—	—
Torticollis	1	—	—	1	—
STUDY 4[4]		"significant"			
Pyramidal tract and acute myalgic disorders	30	27	—	2	1
TOTALS	138	104 (75.3%)	28 (20.3%)	4	2

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"In the author's clinical expe
ence, methocarbamol has
forded greater relief of mus
spasm and pain for a lon
period of time without unde
able side effects or toxic re
tions than any other commo
used relaxants . . ."[2]

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"An excellent result, follow
methocarbamol administrati
was obtained in all patients w
acute skeletal muscle spasm

THE JOURNAL
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"In no instance was there
significant reduction in volunt
strength or intensity of sim
reflexes."[4]

Southern Medical Journal

"This study has demonstrat
that methocarbamol (Robaxin
a superior skeletal muscle rel
ant in acute orthopedic con
tions."[1]

they had covered their waiting room floors with some form of carpeting.

The cost of broadloom or mixed wool and viscose carpeting runs between $8 to $15 a square yard, including underpad. A waiting room measuring 12 x 15 feet would require between $150 to $250 for carpeting, depending on the quality of the carpet and also whether wall to wall carpeting was used. (Most urologists responding did not cover their entire floor dimension with carpet.)

What equipment is needed by the urologist who is completing his residency and preparing to open an office?

RESIDENT PHYSICIAN recently put this question before a number of practicing urologists. Cautioned to keep in mind that cost was an important factor for the new man starting out, many responding specialists described some of the costly mistakes they had made when equipping their own offices.

Based on their experiences, this article is presented as a general guide for those residents who will soon be equipping their own offices for the practice of urology.

Though such things as decor, style and layout of an office are best decided by each physician (or his wife), the resident would be wise to visit an office equipment firm since many offer a free consulting and advisory service. Some will even furnish your entire office on the cuff—and at reasonable bank rates.

Furniture

The basic item of furniture in the waiting room is the chair. Urologists generally allowed for the fact that their patients would often be accompanied by a friend or relative at each visit. Thus, a couch and three other chairs would accommodate perhaps three or four patients. (This, incidentally, was the average accommodation reported by practicing urologists; most were careful in scheduling appointments.)

The type of chair used in the waiting room depends upon various factors. Plastic or leather-covered, and upholstered or foam rubber are equally comfortable. However, as with other specialties, many urologists expressed a preference for the plastic-type chair because of its durability and the ease with which it can be kept clean; a cloth dampened in water is all that is required to care for this type of furniture. There is little to choose between types as

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The unretouched X-ray films show how Lontabs release medication in the digestive tract. So that the prolonged erosion of the Lontab core could be visualized by X-ray, subject was given 10 Lontabs, each containing 100 mg. of a radiopaque substance in place of Pyribenzamine.

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2 hours Lontabs are in the stomach and small bowel. Release of core substance is well under way.

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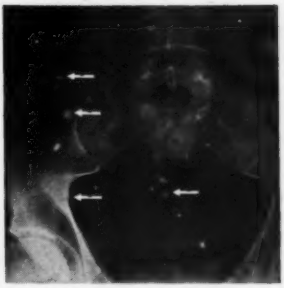

8 hours Lontabs are still visible as substance of core continues to be released.


In potentially-
serious
infections...


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ective against more
n 30 common pathogens,
n including resistant
phylococci.

far as cost is concerned. Any good chair will cost from $30 up to $80. Average price per chair reported by those surveyed was $50.

Necessary items

Other pieces of waiting room furniture required by urologists included lamps, tables for magazines, wall decorations, ashtrays and, if desired, some type of indoor plants. Here again, the urologist will be guided by the ages of the majority of his patients.

Table lamps were preferred, each equipped with no less than a 100 watt bulb and carefully shaded to throw light down on the lap of the patient who wishes to read.

Ashtrays should be plentiful. To prevent the possibility of damage to furnishings caused by spilled ashes or a burning cigarette, buy only the big, bowl-type ash trays; they can be attractive and functional. More than half of the urologists reporting had at least one movable ashtray and stand.

Tables should be sturdy and provide a large expanse of surface to accommodate a sufficient number of magazines and ashtrays. Cost need not exceed $40 for each table—unless you wish to use expensive period furniture. Lamp prices vary from just under $30 to nearly $60. The lower range offers an attractive and durable selection.

Consultation room

The consultation room can be kept simple and uncluttered by limiting the amount of furniture included. Carpeting on the floor adds dignity and together with drapes on the windows, contributes to the sound-proofing of the room.

The major pieces of furniture are those for the urologist himself; a desk and chair. Since a great deal of time will be spent here alone by the urologist, the chair should be one which he has tried and found to his liking in both comfort and appearance. Desk chairs which tilt and rotate can cost from $70 to as much as $200. The main thing, however, is that it fit the urologist comfortably.

Desks vary in price from $75 to $400. The desk should fit the room, not fill it. All consultation room furniture should be in the same style. Other than the physician's own chair, one chair will be provided for the patient (cost $40-$75) and another for a friend or relative of the patient. These, too, should be comfortable so that a lengthy history-taking

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in anti-inflammatory potency

DECADRON "possesses greater anti-inflammatory potency per milligram than any steroid yet produced,"[1] and is "the most potent steroid thus far synthesized."[2] Milligram for milligram, it is, on the average, 5 times more potent than 6-methylprednisolone or triamcinolone; 7 times more potent than prednisone; 28 times more potent than hydrocortisone; and 35 times more potent than cortisone.

in dosage reduction

Thanks to this unprecedented potency, DECADRON is "highly effective in suppressing the manifestations of rheumatoid arthritis when administered in remarkably small daily milligram doses."[3] In a number of cases, doses as low as 0.5-0.8 mg. proved sufficient for daily maintenance. The average maintenance dosage in rheumatoid arthritis is about 1.5 mg. daily.

in elimination and reduction of side effects

Virtual **absence of diabetogenic activity, edema, sodium or water retention, hypertension, or psychic reactions** has been noted with DECADRON.[1,3,3,4] Other "classical" reactions were less frequent and less severe. DECADRON showed no increase in ulcerogenic potential, and **digestive complaints w rare. Nor have there been any new or "peculiar" side effects,** such as muscle wasting, leg cramps, weakness, depression, anorexia, weight loss, headache, dizziness, tachycardia, or erythema. Thus DECADRON introduces **a new order of magnitude in safety,** unprecedented in corticosteroid therapy.

in therapeutic effectiveness

With DECADRON, investigators note "a decided intensification of the anti-inflammatory activity"[3] and antirheumatic potency. Clinically, this was manifested by a **higher degree of improvem** in many patients previously treated with prednisteroids,[3] and by **achievement of satisfactory control in an impressive number of recalcitrant cases.**[3,4]

in therapeutic range

More patients can be treated **more effectively** with DECADRO Its higher anti-inflammatory potency frequently brings relief to cases resistant to other steroids. Virtual freedom from diabetogenic effect in therapeutic dosage permits treatment of many diabetics without an increase in insulin requirements. Absence of hypertension and of sodium and fluid retention allows effective therapy of many patients with cardiovascular disorders. Reduction in the incidence and severity of many side effects extends the benefits of therapy to numerous patients who could not tolerate other steroids. And a healthy sense of well-being, reported by nea all patients on DECADRON, assures greater patient cooperatio

References:
1. Boland, E. W.: California Med. 88:417 (June) 1958. 2. Bunim, J. J., et al.: Arthr. & Rheum. 1:313 (Aug.) 1958 3. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Calif. 4. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., June 21, 1958, San Francisco, Calif.

To treat more patients more effectively in all allergic and inflammatory disorders amenable to corticosteroid therapy

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With proper adjustment of dosage, treatment may ordinarily be changed over to DECADRON from any other corticosteroid on the basis of the following milligram equivalence:

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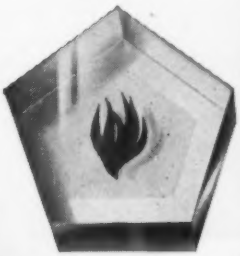
one 4 mg. tablet of	one 5 mg. tablet of	one 20 mg. tablet of	one 25 mg. tablet of
methylprednisolone or triamcinolone	prednisolone or prednisone	hydrocortisone	cortisone

SUPPLIED:
As 0.75 mg. scored pentagon-shaped tablets; also as 0.5 mg. tablets, to provide maximal individualized flexibility of dosage adjustment.



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session doesn't unduly tire the patient.

According to responding urologists, bookcases have a double advantage in the consultation room. They are decorative in themselves, and they provide a storage space for much of the clutter that often finds its way to the top of the specialist's desk. (This last point is of more importance than you may suspect. A sloppy, unkempt desktop often gives the patient the impression that the physician is confused and disorganized—hardly a good impression for any physician to give to a present or future patient.)

Attractive bookcases are not cheap, whether bought ready-made or custom made. However, used bookcases of good quality can be purchased at a considerable saving. Built in bookcases offer an excellent way to utilize odd-sized wall areas, but here too, expense is a big factor—unless you happen to be fortunate enough to have a carpenter or cabinet-maker as a patient.

The majority of urologists surveyed had a viewbox in the consultation room. A large number of the urologist's patients are referred and bring x-rays with them on the first visit which must be read by the urologist. A new viewbox will cost from $25 to $150, depending upon construction and the number of frames.

Cystoscopy room

The average urologist has two examining rooms; one for cystoscopy and one for routine physicals. The major piece of equipment in the cysto room is the cystoscopy table. A simple table can be purchased or one which combines an x-ray unit for retrogrades and intravenous pyelograms.

The majority of urologists reporting (70%) stated they had purchased an x-ray unit immedi-

TWO STEPS TO SAVINGS

1. Consult an office equipment company which maintains an advisory staff having experience in equipping doctors' offices.

2. Make a tentative list of equipment items you think you'll need immediately — together with cost estimates.

ately upon entering private practice. Most of this group felt that the unit pays for itself soon enough to justify its purchase at the beginning.

One reported: "You can't consider yourself a urologist without an x-ray for IVPs and retros—you would be more nearly practicing internal medicine than urology."

The minority who stated they did not purchase an x-ray immediately gave the high cost as a reason for deferring this piece of equipment.

A new cysto table without x-ray may cost as much as $1200. A used table in good condition will be from $200 to $500. The required x-ray unit (100 ma.) will cost from $1200 to $2000. Darkroom equipment and plumbing must also be added to this cost. Average cost of darkroom equipment with a five gallon tank ran under $250 for the surveyed group of urologists, excluding plumbing.

In addition to the table, an irrigation stand will be needed. A complete unit including spotlight will cost from $100 to $150. It will cost less for a wall type unit without the stand. Two stools at about $20 each will complete the table unit grouping.

Cystoscope and cautery

Cystoscopes, of course, are required. The majority of urologists started in practice with two, each costing from $175 to $300.

Roughly a third of beginning urologists purchased an electric cautery. Prices paid averaged $450. The majority reported they did not have nor did they intend to purchase this piece of equipment. "Any required cauterization should be done in the hospital," according to one respondent.

Sounds, catheters

Varying sizes of sounds and catheters are required, of course. A complete set of ureteral catheters is needed. Average total outlay for this group was $150. Commonly found in the cysto room was a wall type viewbox in addition to the one located in the

House call: agitation

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consultation room. Also, a medicine cabinet, average cost near $80, was reported by many practicing urologists.

Other equipment

Additional equipment listed by most urologists included those items needed for routine urinalysis, blood counts and sed rates. A centrifuge, if purchased new, will cost no more than $75. A new microscope will cost from $250 up; secondhand prices usually start at $150.

The average urologist preferred cold sterilization for catheters and sounds. But most indicated the need for a fourteen or sixteen inch sterilizer for instruments and syringes. Purchased new, such a sterilizer will cost in the neighborhood of $75.

Drugs and dye supplies will cost under $50. One point made by a number of respondents was that such items as adrenalin, cortisone and antihistamines should be on hand for the treatment of allergic reactions occurring in the office.

Second room

Many urologists have a second room for basic examinations. This can be equipped simply and at small cost. A suitable table can be purchased for as little as $100 — or a standard examination table can be obtained at prices beginning at $250.

In this room can be located a scale. Cost will be between $50 and $75. In addition, a treatment stand and instrument cabinet can be installed as part of the examining room equipment. Illumination can be from a simple spotlight ($20) or a more elaborate overhead lamp (up to $150).

Extra lavatory

According to many urologists, an additional lavatory, one which is not accessible from the waiting room, should be available to patients in examining and cystoscopy rooms. Furnishing the lavatory with mirror, table, chair, disposal can, etc., should cost less than $75.

Printing

There are a number of incidental items which should be included in the office equipment budget. One of the most important of these, but often overlooked until the last minute, is "printing." This would include your announcements (to let the other doctors in your community know you're in business), personal cards, letterheads, billheads, case records, bookkeeping forms, etc.

The total expenditure you can expect to make for this type of necessary professional printing will be about $75. There are firms which make a specialty of supplying doctors' printing needs. Quite often it will save you time and money to order your forms, stationery, and a bookkeeping system from these specialists. In most cases, you can make all such arrangements by mail.

Basic needs

The foregoing represents the basic needs of the beginning urologist, according to RESIDENT PHYSICIAN poll. The selection made in this discussion of essential equipment comprises an average estimation of that equipment which will be basically useful to the beginning practice. Prices in all cases are for new equipment and give only the approximate range for each category.

Many offices can be (and are) much more elaborately equipped. Also, special consideration was given to price. In modern day merchandising, credit terms can be made so attractive to the beginning practitioner that in many cases it may be wiser to purchase an income-producing item on credit, rather than to defer it.

Average costs

We asked each member of the survey group to give an approximate figure for the cost of outfitting his original office. The figure was to be complete, but excluding such items as typewriters, nurse's desk, nurse's chair, filing cabinet, etc., some of which you may be able to do without.

About half of the urologists equipped their offices with an expenditure of less than $4000. Nearly 30% reported initial equipment purchases of $4000 to $5000. The remainder of the group spent $5000 to $6000.

Incorrect diagnosis in itself is not actionable. But a malpractice action can be brought against a physician if he is negligent in his diagnosis or examination and gives improper treatment.

What the Law Says About Medical Diagnosis

George A. Friedman, M.D., LL.M.

One of the fundamental duties of a physician is to make a properly skillful and careful examination of a patient to discover his condition or ailment.

An incorrect diagnosis is not in itself actionable. A physician does not guarantee his professional judgment; he does not insure the correctness of his diagnosis.

A mother sued a physician for malpractice in the treatment of her son. She alleged that the doctor improperly diagnosed a head injury since he failed to recognize an epidural hemorrhage. The evidence at the trial indicated that the symptoms were not those customarily accompanying such a hemorrhage and that no breach of proper practice occurred.

The court said that the case was at most one of mistaken diagnosis and that mere error in the absence of want of reasonable care and skill does not render a doctor responsible for untoward consequences in the treatment of his patient.[1]

Three conditions must prevail before a physician will be held liable to his patient for an erroneous diagnosis: 1) negligence in the diagnosis or examination 2) followed by improper treatment 3) to the injury of the patient.[2]

One landmark case in the field thus stated the law:

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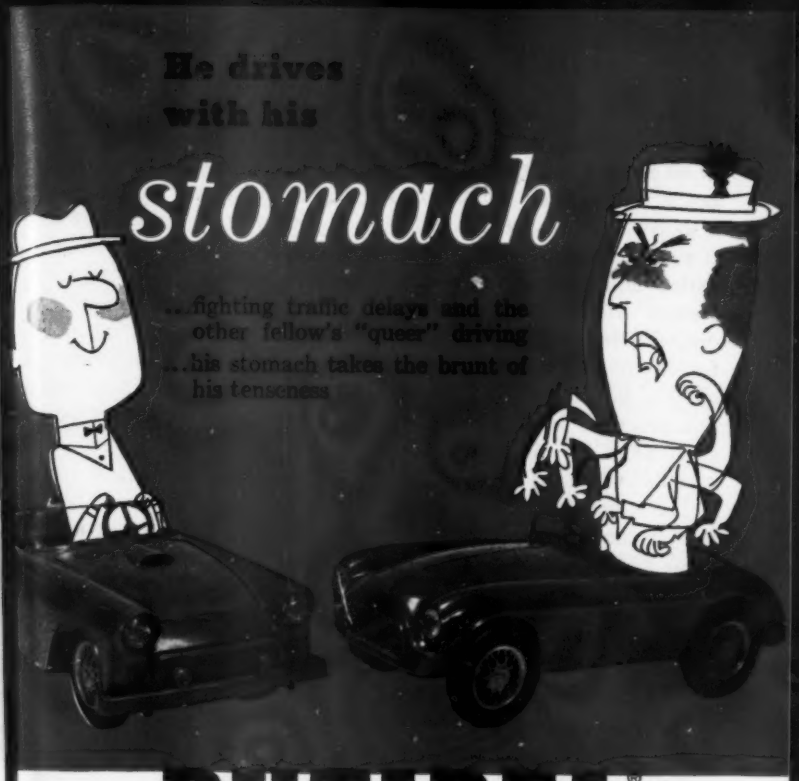
Three conditions must prevail before a physician will be held liable to his patient for an erroneous diagnosis: 1) negligence in the diagnosis or examination 2) followed by improper treatment 3) to the injury of the patient.[2]

One landmark case in the field thus stated the law:



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and that the condition of the deceased justified the second operation. It rejected plaintiff's contention that it was negligent of the defendant to perform the second operation without the assistance of another surgeon.[5]

Unaware

In a 1955 case plaintiff testified that while she consented to a mastectomy she was unaware of the nature of such an operation. She subsequently specifically instructed the physician not to remove her breast and understood that he was simply to excise tissue from the breast for a test. The physician explained to her that the instruments used to make a test were the same ones used to remove a breast.

The physician then proceeded to remove the breast without biopsy and the breast proved to be free of cancer. The court indicated that while the plaintiff would have been bound by her consent despite her ignorance of its meaning, she had a right to withdraw her consent before the operation.[6]

In addition to receiving patient's medical history and making other physical examinations, defendants took x-rays of patient's skull, took an electroencephalogram, performed a pneumoencephalogram and a ventriculogram. They concluded that patient was suffering from a deep-seated brain tumor in the right frontal temporal area and performed a craniotomy.

It was unsuccessful in that they could not locate the tumor. Plaintiff's left side thereafter became paralyzed. Later, a third neurosurgeon discovered the tumor in the base of the right ventricle during another exploratory operation but concluded it was inoperable.

Further operations were palliative only. Defendants were found not guilty of malpractice. They performed all the necessary diagnostic tests to locate a tumor which however proved in this case to have no value. But defendants' failure to find the exact location of the tumor did not establish negligence.[7]

Specialist

Most jurisdictions agree that a specialist is entitled to rely on the diagnosis of the referring physician and treat the patient without making an independent examination. An x-ray specialist treated his patients for a tumor, relying upon the diagnosis of the family physician. In fact, patient was pregnant. The court held that it was proper for the specialist to

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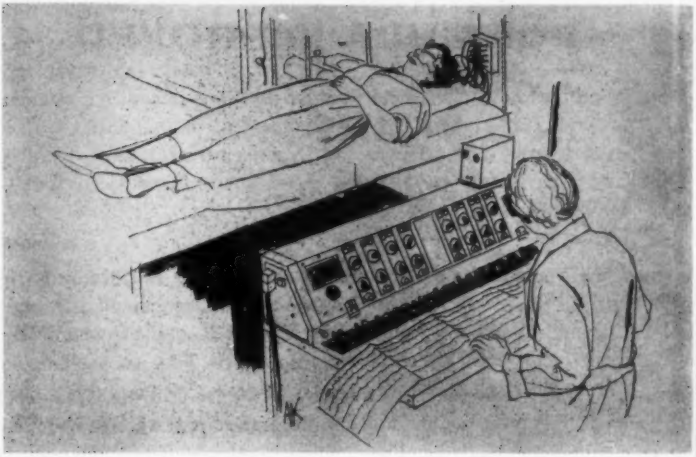

treat the patient on the family physician's diagnosis without making an independent examination.[8]

In a Kansas case in the 1940's, however, defendant physician erroneously diagnosed patient's disease as cancer. Patient went to the Mayo Clinic for an immediate operation. The court held defendant was not liable for the results of the incorrect diagnosis even if made negligently since his services ended with diagnosis.

A vigorous dissent in the case brought out that defendant knew patient would, and in fact, urged patient to act upon his diagnosis. Moreover, the Mayo Clinic was entitled to rely upon the diagnosis. Independent diagnosis would have been time-consuming and defendant urged that no time be wasted.[9]

It is the physician's duty to make use of all available diagnostic aids, including x-rays. Failure to do so under ordinary circumstances constitutes negligence.

Plaintiff was injured in an auto accident. The defendant ordered x-rays of the chest, ribs and upper spine. No fracture of the upper back or neck was disclosed. Plaintiff continued to complain of severe neck pains and indicated other symptoms of a broken neck.

No further x-rays were taken until three weeks after the nega-

tive report of the first x-rays had been received. The later x-rays revealed multiple fractures of the upper spine and neck. Expert evidence indicated that in cases where first x-rays are negative but symptoms of fracture nevertheless persist, further x-rays should be taken.

The court held that a jury might reasonably find that the defendant was negligent in failing to make proper use of x-rays as an aid to diagnosis and that the resultant delay in treatment of fractures of her neck and spine delayed an impeded plaintiff's recovery to her considerable damage.[10] Use of the x-ray, as an aid to diagnosis of brain injuries, has been held a matter of common knowledge.[11]

Held liable

Plaintiff suffered from a fractured vertebra. Defendant, after taking an x-ray, assured him there was nothing wrong with him. Plaintiff suffered great pain for four months, remained in bed most of the time, but attempted to walk pushing a chair in front of him on continued assurances from defendant that he was fine.

He then went to the hospital where his fractured spine was indicated "very obviously" on x-ray. The court held that the defendant's knowledge of this continued suffering should have caused him to doubt the correctness of his diagnosis and to make further examination.[12]

Defendant performed a radical mastectomy on plaintiff without making a biopsy or pathological analysis of the breast tissue. A post-operative pathological analysis indicated no malignancy.

The court held that a jury might from its own knowledge and experience, without expert medical testimony, recognize the use of biopsy or pathological examination and microscopic analysis of tissue as common and accepted diagnostic practice in determining the presence or absence of cancer.[13]

Haste

Valdez v. Hakins[14] was a case in which a surgeon excised a gland and sent it to the laboratory for examination. While plaintiff was still under anaesthesia, the laboratory sent back a report of carcinoma. Plaintiff's right breast was then removed.

When the patient was ready to return to her room, a report came down that the laboratory technician had made a mistake. While the case was dismissed on other grounds, the court indicated the possibility that a surgeon under

such circumstances might be liable for malpractice for "negligent haste" in the removal of the breast.

Defendant failed to make a urine test in treating a diabetic patient. He failed even to take patient's temperature. He treated patient for diabetic coma instead of for insulin shock.

The court held defendant should have discovered the patient's true condition. The symptoms of the two conditions are quite different, and in any event, witnesses testified to the importance of urine tests in diagnosing the condition of a diabetic patient.[15]

Proximate cause

A plaintiff must establish a casual relationship between defendant's lack of skill and patient's injury. An incorrect diagnosis can produce harmful results either by failing to give or depriving the patient of the proper treatment or by aggravating the condition by harmful treatment.

In order for a plaintiff to recover damages from a law suit based on failure to give or deprivation of proper treatment, it is essential to prove that the original condition would have responded to proper treatment in the first place.

The physician negligently diagnosed decedent's condition as intoxication when examining him after an automobile accident. Expert witnesses testified that decedent would have died in any event from the traumatic injuries to the head received in the accident; it was uncertain whether decedent's condition was aggravated or his death accelerated by the negligence. No recovery was had.[16]

Similarly, no damages will be allowed if the treatment based upon erroneous diagnosis turns out to be proper or at least not harmful to recovery. A physician erroneously diagnosed plaintiff's backaches as pregnancy. He prescribed rest, quiet and freedom from excitement which would not have been harmful to plaintiff's real condition.

Other physicians had previously erroneously diagnosed patient's case as tumor. The court held that there was no causal relation between the injury and the treatment.[17]

Brain injuries

Defendant made an incorrect diagnosis of torn ligament and strained muscles when in fact plaintiff suffered from a dislocated and fractured hip.

Rest and massage were prescribed which an expert testified

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was the common and correct treatment for the condition which actually existed.[18] No recovery was had.

Two kinds of diagnostic cases which often turn upon proximate cause are diseases or injuries of the brain and fractures.

Plaintiff was brought to defendant's hospital in a coma. Without giving her the standard blood or urine test to determine her condition, defendant diagnosed plaintiff as an acute alcoholic and turned her over to the police. In fact, plaintiff was a lifetime teetotaler and was suffering from a clot on the brain. Defendant was guilty of malpractice.[19]

In a 1937 case the court held that a permanent shortening of the plaintiff's leg was clearly the result of defendant's negligence in failing to diagnose and treat her fractured hip. When plaintiff was brought into the hospital after an accident, there was evidence that she had groaned and rubbed her hip while unconscious, and had given indications of pain in the hip after regaining consciousness.[20]

Pregnancy

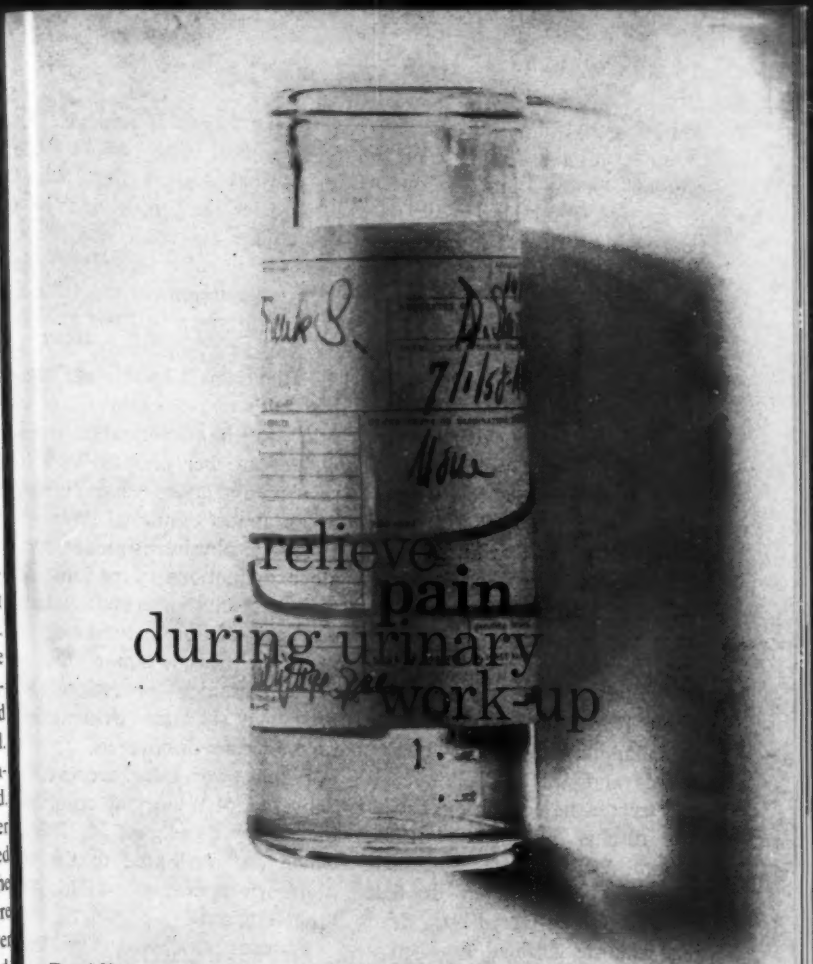
Numerous cases have arisen in which physicians have mistakenly diagnosed tumors as pregnancy or vice-versa. The prime issue in such cases often is whether the physician exercised less care than he should have in the examination of the patient, either by hasty examination or failure or misuse of diagnostic aids. The erroneous diagnosis, even one leading to an unnecessary operation, is not in itself actionable.

Defendants advised patient she was two months pregnant and afflicted with fibroid tumors. They advised an early operation to remove the tumors.

Upon operating they discovered no tumors; instead patient was well advanced in pregnancy. The wound was closed in the usual manner but because of patient's condition the tissues did not reunite and a hernia resulted.

Three months after the operation, patient gave birth to a child. During those months and after the birth of the child, she endured much pain and suffering. The court held that defendants were negligent in failing to discover patient's true condition and in advising an operation.

Specifically, the negligent acts were: 1) acting too hastily and failing to keep patient under observation for a longer period of time 2) failure to use stethoscope or x-ray in diagnosing he



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condition 3) failure to use ballottement tests 4) failure to make physical examination just prior to the operation and while patient was under anaesthesia.[21]

Not detected

A physician, Dr. W, engaged to treat patient during her confinement, delivered her of one twin, but failed to discover the presence of the other twin. When patient did not recover from childbirth as expected, within two days after birth, Dr. W turned her over to Dr. Y with full consent of plaintiff and her husband.

Dr. Y was advised that some years ago, a large ovarian tumor was removed by operation. Patient was placed in hospital where Dr. Y diagnosed the case as inflammation, tumor, locked bowels and gas on the stomach and treated her accordingly. She was discharged in two weeks.

Some 20 days after birth, patient was removed to another hospital and delivered by a third physician of a dead fetus in a badly decomposed condition. The uterus had been ruptured and fetus was removed from the abdomen. Patient died a week later.

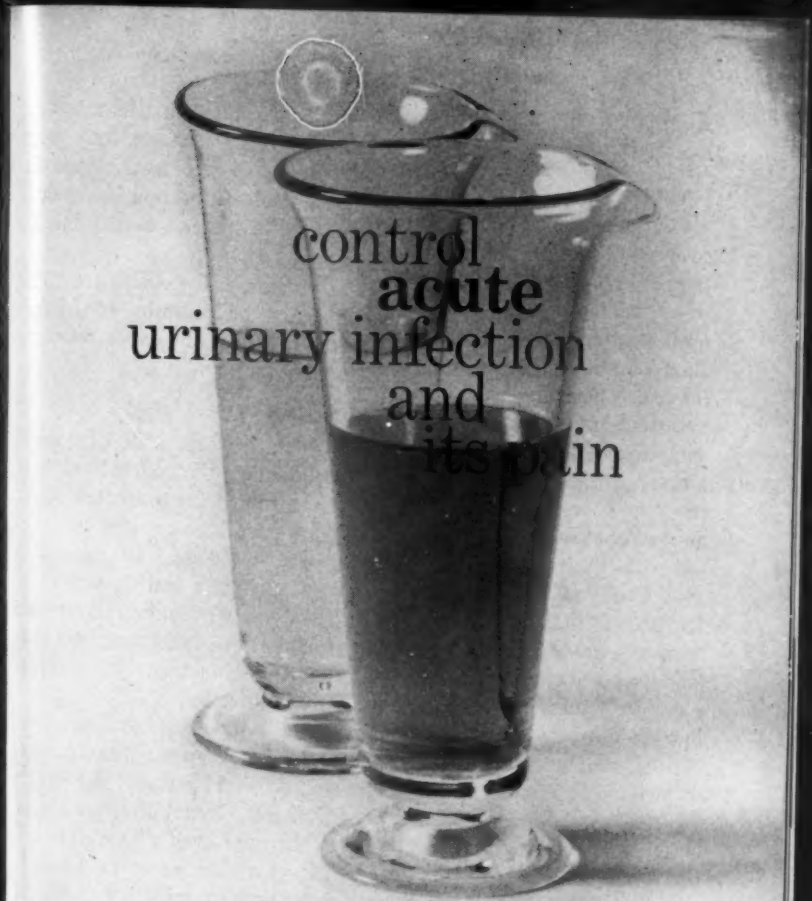
The court held that Drs. W and Y were not guilty of negligence in their diagnosis or treatment. Each had used ordinary care; moreover there was evidence that an operation upon patient while in her weakened condition would have been dangerous and even though the diagnosis was incorrect, the treatment received was the proper treatment that should have been given had the doctors known her true ailment.[22]

Patient was 47 years old. She had delivered a child 12 years prior to the examination complained of; her periods were irregular and were characterized by an almost continual flow.

Several physicians made separate examinations of patient and their consultation resulted in a diagnosis of fibroid tumor of the uterus or ovarian tumor. During an exploratory operation, the pregnancy became evident; no tumors were discovered.

Patient was later successfully delivered of a normal child but thereafter developed a hernia which she attributed to the exploratory operation. Held: for the defendants.

Patient's case was a particularly difficult case to diagnose and an exploratory operation under the circumstances was not only the wisest course to pursue but was necessary and in accordance with good practice. Also expert testimony was almost unanimous to the effect that the



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hernia was not caused by the incision.[23]

Expert testimony

Expert evidence is essential to sustain almost all actions for malpractice based on alleged negligence or unskillfulness in diagnosis. While there is a restricted class of medical cases in which the courts have held that the mere happening of events raises a presumption of negligence, as for example, where a surgical instrument or sponge has been left in an incision, diagnosis does not fall within this restricted class.

A California court noted in a 1951 case that the doctrine of *res ipsa loquitur* (the thing speaks for itself) could not be applied to a question of diagnosis in a brain injury since "the merits of such a diagnosis were matters of medical learning, peculiarly in the knowledge of experts."[24]

The court went on to say that the doctrine of *res ipsa loquitur* was limited to malpractice cases where "negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge."[25]

Defendant physician diagnosed patient's ailment as neuritis instead of arachnoiditis which it was later proven to be. Plaintiff offered no expert witness. Defendant testified that he made no further tests because they were "painful, unnecessary, inadvisable, and in his opinion, would have told him no more than he already knew."

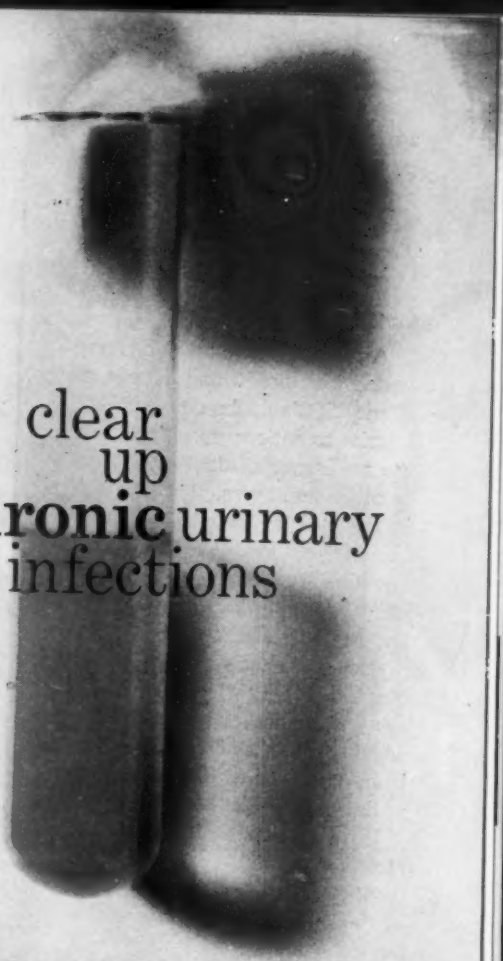
Judgment: for defendant. The question of necessity of further tests was one for expert medical testimony.[26]

Obvious

In a few cases of diagnostic malpractice, the courts have held that on the facts presented negligence could be proved by non-expert witnesses. In one such case, plaintiff's malady was diagnosed as a common cold and rheumatism. She was actually suffering from hemolytic streptococcus infection.

The symptoms, swelling of the body, black spots, muscle soreness so as to prohibit the weight of sheets, immobility, etc., were all there for even a layman to see. The physician, however, failed to make such examination of the patient as would have disclosed her real condition.[27]

The courts have held also that use of x-ray as an aid to diagnosis in certain cases such as fractures is a matter of common knowledge. Failure to use x-ray in such a case may be considered by the jury without the aid of expert



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advice. Some courts are inclining toward the view that use of pathological analysis of tissue as an aid to diagnosis in neoplastic diseases should be placed in the same category as x-ray.

Liability of hospitals

A private hospital which is operated for profit and is not a charity is liable in damages for injuries to patients resulting from the negligence of doctors, nurses or other employees. The hospital in the care of its patients must exercise such reasonable care and attention for their safety as their mental and physical condition, if known, may require.

The most common issue of hospital liability where the allegation is improper diagnosis is whether the attending physician is an employee of the hospital or an independent contractor.

In *Edwards v. West Texas Hospital,* discussed previously, no liability attached to the hospital in which physician defendants treated patient. The hospital was incorporated and organized as a hospital and sanitarium for the purpose of furnishing accommodations and facilities for the sick and afflicted.

It furnished rooms, beds, linens, food and operating equipment. It did not undertake to practice medicine or surgery or to direct in any way the diagnosis or treatment of patients.

It merely furnished to patient such facilities as were usually furnished by hospitals to physicians and surgeons who might see fit to place such a patient in its hospital. Defendant physicians were independent physicians and not in the employ or control of the hospital.

Dr. H was a member of the hospital's medical staff. Patient appeared to be in normal labor and he turned her over to Dr. C, another staff physician. Dr. C made a cursory examination some nine hours later and concluded all was well.

Within 15 minutes, patient suffered a convulsion and a child was delivered by forceps in another 15 minutes. Both doctors again found her to be normal. Five hours later, patient suffered another convulsion and died.

The court held the hospital liable on the theory that its employees, both doctors and nurses, were negligent in not discovering before or after birth that patient suffered from eclampsia.[28]

Statute of limitations

Plaintiff injured his leg in a motorcycle accident on December 31, 1950. On the same day

defendant had the leg x-rayed and concluded patient was suffering from torn ligaments, treated by bandaging plaintiff's leg.

The pain became so intense that on January 2, 1951, plaintiff consulted with another doctor who told him he had a fractured leg which showed evidence of subsequent splintering.

The California statute of limitations for malpractice is one year. Plaintiff filed suit May 16, 1952, claiming that while he was aware of the improper diagnosis on January 2, 1951, he was unaware it had caused further injury to his leg until July 1951.

Held: the action was barred by the statute of limitations. The knowledge of improper diagnosis imposed upon plaintiff the duty of ascertaining the effects of that erroneous diagnosis. Even a layman knows that placing weight on a broken bone is not beneficial.[29]

In 1942 plaintiff fell and broke her ankle. Defendant physician x-rayed the ankle and gave the diagnosis that the main bone was not broken, only the little bone, and treated her accordingly. Over the years, plaintiff complained about her ankle to defendant.

In 1953, plaintiff sued defendant for malpractice, alleging that the three year statute of limitations was tolled by defendant's fraudulent concealment of the facts. Held: for defendant. There was no evidence of such fraudulent concealment.[30]

Damages

Plaintiff's small grandson fell from an automobile. Defendant examined him, said there was nothing much wrong and sent him home. The child died of a skull fracture a few days later.

The court held the grandparents were entitled to $500 medical and funeral expenses and $2000 damages for mental anguish since they stood in *loco parentis* to the child.[31]

A patient was awarded $5,000 damages against a chiropractor who erroneously diagnosed and treated plaintiff for a misplaced vertebra when she suffered a tumor or lesion of the brain. Her eyesight was impaired and she lost partial use of her right arm and leg. She spent over $2,000 for necessary hospital, medical care and attention.[32]

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24. Huffman v. Lindquist, supra, footnote 1.
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"The experiment's over. We just can't get him to quit."

How to Speak Polish: Key Words for the Clinic

You don't have to be a language expert to handle a medical history and examination of a non-English-speaking patient. Here are medical words and phrases to help you break the language barrier.

In the Polish translation that follows, you will find no written Polish. Instead, the pronunciation of the Polish equivalent of each English word listed is indicated by a manufactured word in English. By saying the strange-looking word formations aloud (just as you would if they were real English words), you will approximate the sound of the Polish or perhaps it would be more accurate to say you will be in the general vicinity of the correct Polish pronunciation.

Remember, there are many Polish sounds which have no equivalent in English. On many words you will be "close, but not quite." However, the purpose of this translation is not to make you a linguist, but simply to give you a concise and handy pronunciation guide by which you may more easily communicate with the foreign-born patient. If we were to list all the rules of pronunciation along with the written Polish, this guide would undoubtedly help you to a more accurate pronunciation—but at the same time it would be so cumbersome and technical as to defeat its original purpose of being quick and easy to use during an examination or history of your patient. Incidentally, we do not use the standard phonetic alphabet since few individuals can *sight read* phonetics.

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Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.

Texas License

It has been called to our attention that in your recent medical journal RESIDENT PHYSICIAN, April 1958, page 67, that neither first papers nor citizenship are required for licensure in Texas. Please be advised that an applicant to be eligible for licensure in Texas must be a citizen of the United States or have filed his declaration of intention to become a citizen.

M. H. Crabb, M.D.
Secretary
Texas State Board of Medical Examiners
Fort Worth, Texas

Licensure

In your February issue you announced the publication of "Licensure for Foreign Graduates" in tabular form in a future issue of RESIDENT PHYSICIAN. Would you be kind enough to forward to me one of these issues?

Otto A. Kurz, Capt., MC
Evac Hospital
San Francisco, California

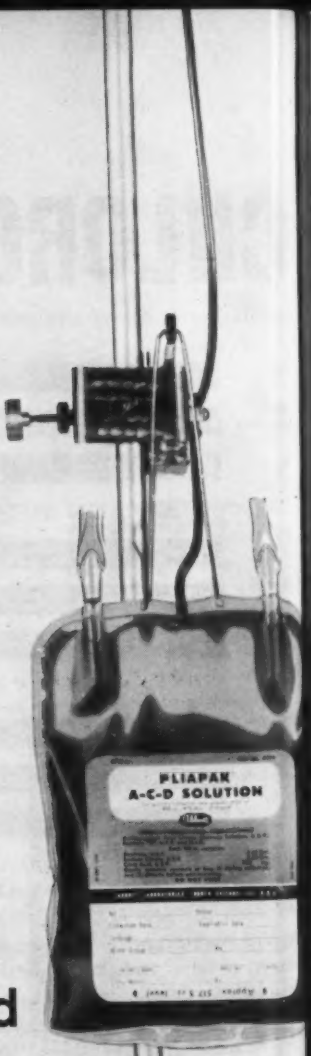
• *Copy on the way.*

New Programs

We're enclosing a news release and photo about new internships and residencies to be offered beginning next year here. We'd like to get the word out as soon as we

—Continued on page 34

No. 3 in a descriptive series on Abbott specialties



what's behind the trend toward plastic blood containers?

Maybe you've seen it yourself in recent months: the familiar glass blood bottle is more and more often being replaced by a plastic bag.

What's behind this shift? Is the bag proving more serviceable than the bottle?

Let it be noted here that Abbott supplies both—and can impartially state that both give excellent results. Obviously, however, certain characteristics must be singled out to account for the ever-increasing appearance of the new plastic bag.

First of all, procedure is somewhat simplified. The collection tube of the Pliapak®, Abbott's Plastic Bag, is permanently attached. Just uncover the sterile needle, and the unit is ready for phlebotomy. There is one less step of entering the container, with its attendant care.

This attached collection tube can also serve as an integral pilot tube. It permits several samples to be taken without entering the bag.

The bag centrifuges in a standard water-filled cup, and since it is flexible, plasma can easily be expelled.

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—Continued from page 30

can about these, because we know those who might be interested are laying their plans right now for next year's activities. Thanks very much for anything you can do for us to help publicize these new programs.

Seymour Standish, Jr.
Assistant to the Chairman
Board of Health Sciences
University of Washington
Seattle, Washington

• *We wish you success with your new program.*

New internship and residency programs will be offered by the University of Washington School of Medicine, Seattle, beginning July 1, 1959.

These will be centered around the new University Hospital, which expects to receive its first patients next May and will gradually build up to its 300-bed capacity over a period of months.

During the build-up period, other Seattle hospitals closely affiliated with the University will be used to give a rounded program of well-supervised patient responsibility. These are King County, Veterans Administration and Children's Orthopedic Hospitals, with a bed capacity totaling more than 900.

The University Hospital will be a teaching and research hospital, staffed by the University faculty and located on the University campus adjacent to the Health Sciences Building. It will feature a large outpatient clinic, a rehabilitation center, an inpatient psychiatric department and a premature-infant center, in addition to the regular features of a modern teaching hospital.

Twelve internships will be offered. Three will be rotating and nine mixed. Four of the mixed internships will have a major in medicine, four a major in surgery and one in pediatrics. Intern stipends will be $150 per month plus $30 food allowance. Uniforms and laundry service are free. Housing will be the intern's responsibility.

Residencies will be offered in most of the services of the new hospital. Residents will also make use of the facilities of affiliated hospitals.

Inquiries regarding these programs should be addressed to Medical Director, University Hospital, University of Washington, Seattle 5, Washington.

Medical Secretary

I have just read with great interest an article in a recent issue

—Continued on page 40

FOR EXAMINATION OF POLISH-SPEAKING PATIENTS:

Basic rule of pronunciation

g is always pronounced hard as in *go, give,* never as g in ginger.

Anatomical terms

head	glaw-vah	neck	sheeyah
eyes	awchee	chest	klahtkah pee-air-showvah
ears	ooshee	heart	sehrt-seh
nose	nawz	lungs	ploo-tsah
mouth	oostah	shoulders	bar-kee
teeth	zahmbee	back	pletsee
tongue	yehnzek	arm	rahm-yeh
throat	gardlaw	bladder	pan-kash
finger	pahlats	stomach	shahlon-doc
legs	no-gee	rectum	kishah awd-kawddovah
feet	stawpee	buttocks	tilleck
hands	reh-see	womb	mah-chitzah

Directions to patients

do as I do	rawbich toe so ya rawbyeh
relax	awdprehshich sheh
relax more	vyehcheh sheh awdprehshich
open your mouth	awdvawshich oostah
open your eyes	awdvawshich awchee
breathe deeply	awdickach glehboko
breathe through your mouth	awdickach pshaz oostah
hold your breath	zatsheemach awdech
push	puhnawch nahpnawch sheh
cough	kahshlach
please don't move	prawsheh sheh nyeh rooshach

Courtesy phrases

Good morning, Sir	jen dawbry pahnue
Good evening, Madam	dawbry v-yetshur

Good night	dawbrahnawts
Please	prawsheh
Thank you	jenk-you-eh
Please sit down	prawsheh you-sheeshch
How are you?	yahk shee chew-yehchee
Very well thanks	bardzaw dawbr-jeh jenk-you-eh
May I help you	chee mow-geh pawmuts
Do you understand	rawzumyesh
Pardon me	pshahprahshahm
Very good	bardzaw dawbr-jeh
Today	chishay
Tomorrow	yewtro
Yesterday	vuhchoray

General questions

do you feel sick	chee chew-yehcheh sheh kor-rim
do you have pain	chee mahcheh booleh
—much pain	—awstreh booleh
—mild pain	—slahbeh booleh
where	guhjeh
here	tootay
when	k'yaidee
how many years	illeh latt
how many days	illeh'dnee
how many hours	illeh gawjin
how many times	illeh rahzy
where were you born	guhjeh uhrawdzony
how old are you	illeh mahcheh latt

Diseases

measles	awdra
scarlet fever	shcarlahteena
chicken pox	vyechna awspah
small pox	awspah
pneumonia	zahpahlenyeh plootz
typhoid fever	tyfuss

enteritis	zahpahlenyeh kishehk
U.R.I.	zahpahlenyeh goornych drog awdehchowich

Systemic inquiry

Head	
trauma	oodehshenee
unconscious	nyepsheetomnee
did you faint	chee m'dleh-lish-cheh
are you dizzy	chee mahcheh zavrawty glaw-vee
headache	bull glaw-vee
Eyes	
sight	vzrawk
clear vision	virahshnee awbrass
near	bleesko
far	dahlehko
Ears	
he is deaf	on yest glookee
noise in the ears	shumm vuh ooshahk
Nose	
coryza	kahtar
did you have a nose bleed	chee mahcheh krah-vah vyen yeh nawsah
Throat	
do you have frequent sore throat	chee macheh chensteh booleh gardlah

Cardio-respiratory

do you tire easily	chee lehko oolehgahcheh smehchenyoo
are you short of breath	chee brahkooyeh vahm awdekoo
does your heart beat fast	chee mahcheh pchee-speeyay-shawnay bicheh sersah
do your feet swell	chee pooknaw no-gee
do you have pain in the chest	chee mahcheh booleh vuh plootzahk
sharp pain	awstree bull
dull pain	tehpee bull

when you breathe	pchee awdichahnyoo
do you cough	chee kashlehcheh
do you spit	chee sploovahcheh
sputum	puhlvachinah
bloody sputum	puhlvachinah zuh kriv-yone
have you lost weight	chee strachlishcheh nah vah-zeh
does someone in your family have a cough	chee kuhtahsh zuh rojinee kashlahl

Gastrointestinal

do you have a good appetite	chee mahcheh dawbry apehtit
do you have a poor appetite	chee nyeh macheh apehtit
are you nauseated	chee chee-ehcheh vimee-awtovach
were you nauseated	chee k'cheh-lishcheh vimee-awtovach
do you vomit	chee vimee-awtehyecheh
do you have diarrhea	chee mahcheh roz-vall-nyeh-nyeh
are you constipated	chee mahcheh zahtvard-jenyeh
did you have a B.M. today	chee mee-elishcheh jishay stawlets
feces	
black	charnee
white	beeyellee
yellow	shuhltee
brown	brawnsovee
bloody	krah-vah-vee
do you have cramps	chee mahcheh koorcheh
after meals	po yedzenyew
before meals	pshed yehjenyem
did you take a laxative	chee brawlishcheh nah psheh-chish-chehnyee
did you take castor-oil	chee brawlishcheh olay reetseenovee

Genitourinary

urine	mawch

do you get up at night to urinate	chee viztayecheh vuh nawchy awdahvahch mawch
does it burn	chee p'yecheh
chills	dreshcheh
fever	guh-rahnch-kah

Obstetrics and gynecology

at what age did you begin to menstruate	keeyaidee mee-elishcheh p-yairvshah menstrooats-yeh
How many days do you flow	yahk d'loogaw menstrooyetsee
1 to 10	roz, d'vah, cheh, shteveh, pee-ench, sheshch, shedem, aw-shum, jev-ench jeshunsh
do you have a discharge	chee mahcheh ooplahvee
when was your last menstrual period	keeyaidee awstaht-neo mee-elishcheh menstrooyets-yeh
are you pregnant	yes-tesh-tschee vuh kee-ah-shee
do you have pain with your period	chee mahcheh booleh podtshohs menstrooats-yeh
how many times have you been pregnant	illeh rahzee beelishcheh vuh kee-ah-shee
how many children have you had	illeh mee-lishcheh jet-shee
how much did the largest weigh at birth	yahkah nay-vyenkshah vahgah beelah p'chee oorawzenyoo
what was the duration of labor	yahk d'loogaw truhvahlee booleh porawdo-veh

Pediatrics

was there any trouble with the child's delivery	chee pawruhd bill skawm-pleekahvanee
how are the child's stools	yahkee yest jets-kah stawlets
—constipated	—zawt-vahrd-shawnee
—diarrhea	—roz-vall-yony
—how many a day	—illeh rahzee jenyeh
does the child eat well	chee jeh-kah yeh dawbr-jeh
any vomiting	chee vimee-awtoyetsheh

does the child turn blue	chee jeh-kah sheen-yieyeh
does the child seem tired	chee jeh-kah veeglondah smenchawneh
does it hurt	chee bowlyee
it won't hurt	taw neh ben-jeh bowlech
it will be over in a minute	taw skonchee shieh tsa chvilleh
do you want a piece of candy	cheesh tsookee-airkuh
did you take the temperature	chee mee-eshy-lesh-shee gorahnchkuh
what was the temperature	yahkah gorahnchkah
what a big handsome boy	yahkee lahd-nee klawpuk
what a beautiful little girl	yahkah schitshnah jeff-chinkah
baby	nee-maw-vleh
good	dawbsheh

Mediquiz

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association.*

Answers will be found on page 183

1. Which one of the following questions would be most effective in eliciting a history of digitalis intoxication from an individual receiving an excessive amount of this drug?

   (A) Do objects appear to you as if they are being seen through a red glass?
   (B) Do you have a sensation of snowflakes in front of your field of vision?
   (C) Do you see double?
   (D) Do you notice the appearance of a rainbow about the outlines of objects?
   (E) Do objects appear to you as if they are being seen through a colored glass?

2. The oxygen capacity of 100 ml. of human blood is:

   (A) 1.34 ml.
   (B) 5 ml.
   (C) 10 ml.
   (D) 20 ml.
   (E) 200 ml.

3. Taking into account variations in therapeutic response depending upon duration and severity of the disease, which one of the following statements on cardiac decompensation in beriberi heart disease is true?

   (A) Digitalis is of little or no value but thiamin causes dramatic compensation.
   (B) Large volumes of plasma should be given if the beriberi is of the 'wet' type, in order to correct

---

NOTE: If you are interested in preparing questions for *"Mediquiz"* or the Professional Examination Service, write for information to the Professional Examination Service, 1790 Broadway, New York 19, New York.

the loss of blood protein.

(C) The EKG usually shows high voltage in all leads except CF 2.

(D) The heart rate is slow in contrast with the usual rapid rate seen in failure from other causes.

(E) The Q-T interval in the EKG is considerably shortened.

4. In multiple myeloma, the serum alkaline phosphatase is usually:

(A) Impossible to determine.

(B) Very variable.

(C) Normal.

(D) Depressed.

(E) Elevated.

5. A 60-year-old Jewish male has gangrene of the foot because of thrombosis of the popliteal artery. His blood Wassermann reaction is 4 plus. The underlying vascular lesion is most probably:

(A) Mönckeberg's sclerosis.

(B) Periarteritis nodosa.

(C) Atherosclerosis.

(D) Thromboangiitis obliterans.

(E) Syphilitic aortitis.

6. The only one of the following anemias which, without disease of the liver, is charac-

terized by an abnormal brownish-yellow color of the blood plasma is:
(A) Myelophthisic anemia.
(B) Aplastic anemia.
(C) The simple chronic anemia of infection.
(D) Pernicious anemia.
(E) Hypochromic anemia.

7. Schimmelbusch's disease of the breast is a variety of:
(A) Carcinoma in situ.
(B) Intraductile papilloma.
(C) Fibro-adenoma.
(D) Involutionary failure.
(E) Chronic fibrocystic disease.

8. A patient has a sudden onset of unconsciousness. His face is flushed or cyanosed. His skin sweats profusely. He breathes stertorously, has high blood pressure and a slow pulse, full and bounding. His limbs are all flaccid but on comparing the two sides, the flaccidity is more absolute on one side. This patient should be suspected of having:
(A) Epilepsy.
(B) A brain tumor.
(C) An hysterical fit.
(D) A spontaneous cerebral hemorrhage.
(E) Catalepsy.

What's the Doctor's Name?

by Victor R. Jablokow

Eldest of 11 children of an English publisher, she was born in London on Aug. 31, 1842, and came to the U.S. in 1847.

She was one of the first of women doctors, her father placing no barriers before her "repulsive pursuit."

She was graduated in 1863 from the New York College of Pharmacy and in 1864 from the Female Medical College of Pennsylvania (later the Women's Medical College). Considering her medical training to be inadequate, she went to Europe in the hope of studying at the École de Medicine of the University of Paris.

She was refused entrance at first to the École because of her sex and worked in hospital clinics and laboratories, attended lectures at the Jardin des Plantes and College de France and earned her way by writing

for American newspapers and such journals as *Putnam's Magazine* and *Scribner's Monthly*. Her eventual acceptance was so delayed that she became the second rather than the first female graduate of the École, a practicing English physician, Dr. Elizabeth Garrett, having meantime beaten her to the honor.

She returned to New York in 1871 and became a professor on the faculty of the new Women's Medical College of the New York Infirmary, a position she held for 25 years.

Dr. William Osler said of her talent that "she stood as a bright particular star in the firmament of the profession . . . It is no disparagement to her contemporaries to say that no other woman in the profession equalled her in the ability with which she presented a subject." She was a brilliant student, writer, teacher and lecturer.

In the same year that she was elected to the Medical Society of the County of New York she married its president, himself a major figure in American medicine.

She was a leader in work in behalf of the American Indian, the Negro and women's suffrage. She died on June 10, 1906.

Can you name this doctor? Answer on page 183.

RP REVIEWS BOOKS

About Doctors

Conducted by SAUL A. KUCHINSKY

DOCTOR AND PATIENT IN SOVIET RUSSIA. *Mark G. Field. Cambridge, Harvard University Press. $5*

The author in the summer of 1956 visited the Soviet Union for four weeks with a group of distinguished American doctors that included Paul Dudley White and Howard Rusk. The result for him was an amplification of his Harvard Ph.D. thesis into this book. It is a sociological study of the Soviet doctor and medical system and evolves as an indictment of the Soviet state but a testimonial to its doctors.

The book is not intended as quick or popular reading. Its language is academic and even jargoned. But the material is objectively and earnestly gathered and presented and, in our sputnik age of heightened curiosity about the Russians, certainly pertinent enough to deserve a reading.

Dr. Field based his book not only on his visit but on interviews in the U. S. with ex-Soviet

doctors.

The author finds that Soviet medicine, like every other Soviet institution, exists only for the molding of the Socialist state. Ever further industrialization is the state's unrelenting goal. What are the problems for the doctor? The state demands every available worker for its industrial plant, regardless of his condition. By intimidation of the doctor, by the setting of improper norms of physical fitness, it drafts the unfit into factory and mine. The doctor who certifies too many workers as sick finds himself in trouble. The worker who does not become a clever malingerer is soon exhausted. The end result often is that doctor and patient are cast in the role of adversaries, with both fearful of punishment by the state.

It is to the everlasting credit of the Soviet doctor that he is, in such circumstances, a respected figure on the Soviet scene. The "zemstvo" physician of Chekhov's day, idealistically devoted to his patient, has endured. But if the people have affection for their doctors, also for their system of free medicine, they are plainly disenchanted by their totalitarian state.

VIEWBOX DIAGNOSIS

(from page 23)

OSTEOBLASTIC METASTASIS FROM CA. OF THE PROSTATE

Note the numerous blastic areas with no enlargement of the bones. Note absence of cortical thickening.

●

MEDIQUIZ ANSWERS

(from page 170)

1 (E), 2 (D), 3 (A), 4 (C), 5 (C), 6 (D), 7 (E), 8 (D).

●

WHAT'S THE DOCTOR'S NAME?

(answer from page 173)

MARY PUTNAM JACOBI

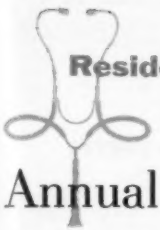
●

RESIDENT RELAXER

(puzzle on page 25)

P	A	I	N		E	S	T	E	R		T	R	E	P
O	N	T	O		N	U	R	S	E		R	A	K	E
S	A	C	S		T	R	A	P	S		A	V	E	R
E	T	H	O	L	O	G	Y		O	S	C	E	D	O
			L	A	M	E		G	N	A	T			
A	L	L	O	S	E		T	R	A	N	S	F	I	X
G	A	U	G	E		C	R	A	N	E		I	N	E
R	U	B	Y		C	O	U	N	T		N	E	O	N
I	D	B		G	R	I	S	T		D	E	R	M	O
A	S	S	O	N	A	N	T		L	I	B	Y	A	N
			M	A	W	S		G	E	N	U			
S	P	R	A	W	L		R	E	S	T	L	E	S	S
L	U	N	G		I	D	E	A	S		I	L	E	O
A	C	O	R		N	I	T	R	E		Z	E	A	L
M	E	S	A		G	E	E	S	E		E	C	T	O

Resident Physician Advertisers' Index December 1958



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The following articles are by George A. Friedman, M.D., LL.M.

ETHICS AND ETIQUETTE

EDITORIALS

BOOK REVIEWS

PHARMACEUTICAL COMPANY FOUNDERS

Doctors, too, like "Premarin"®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

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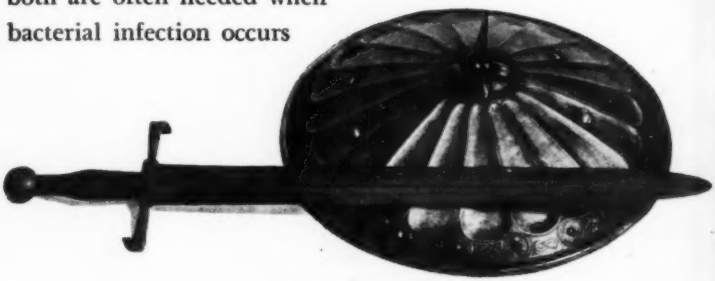

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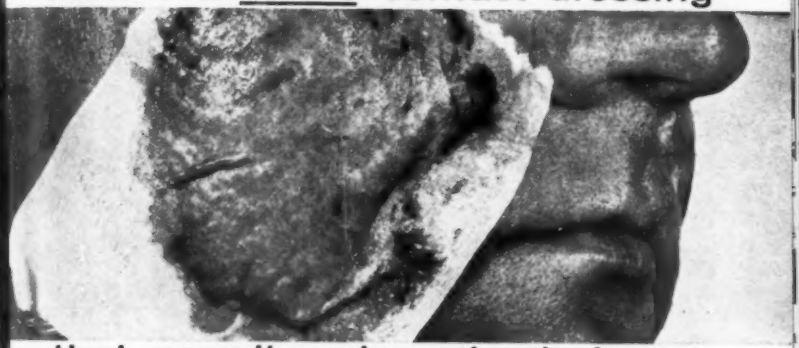

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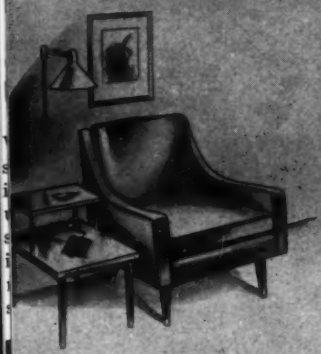

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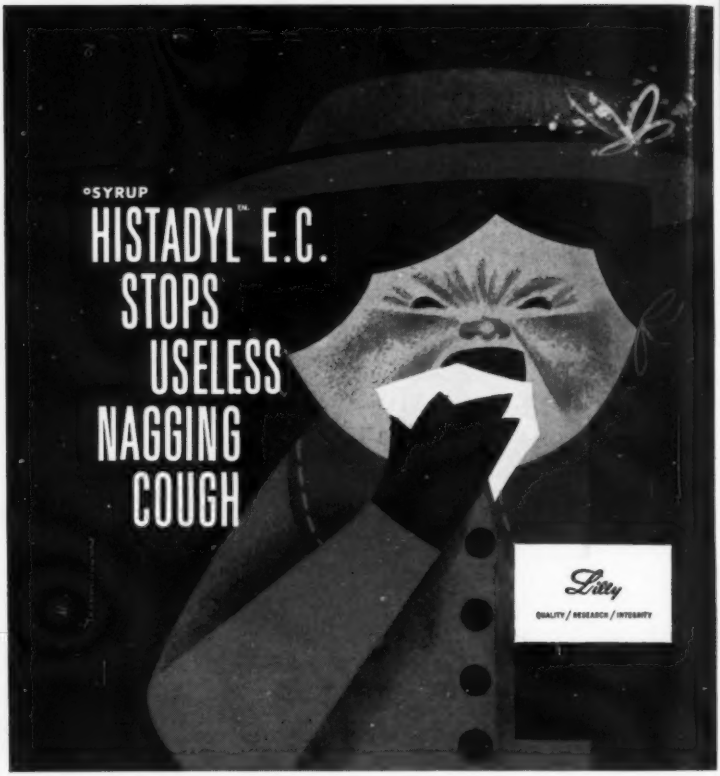

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PSYCHIATRIC RESIDENCIES — Edward J. Meyer Memorial Hospital, (University of Buffalo, School of Medicine) offers three year approved training on the Psychiatric service of a large general hospital. Active teaching program with excellent clinical opportunities for training, supervision, teaching and research. Stipends—1st year—$3675; 2nd year—$4575; 3rd year—$5275. Write: Dr. S. Mouchly Small, Professor of Psychiatry, 462 Grider Street, Buffalo 15, New York.

WORCESTER CITY HOSPITAL, Worcester, Mass. (450 beds); Board approved rotating internship and residencies in Medicine (3 years); Surgery (4 years), Pediatrics (2 years); Pathology (3 years) and Orthopedics (2 years, adult). Large proportion of active ward service cases with excellent teaching staff and opportunity to learn. Daily teaching conferences and bi-weekly guest physician conferences. Annual stipend $2400-interns; $3000-$4000 residents, including maintenance. Applicants must be graduates of approved schools or take A.M.A. qualifying examination. Reply to Dr. Victor P. Di-Domenico, Director of Medical Education.

RESIDENCIES—FULLY APPROVED—377 bed GM&S VA Hospital, affiliated with the Johns Hopkins University and University of Maryland Medical Schools; Internal Medicine and General Surgery: Salary $3250-$4945. Address inquiries to Director, Professional Services, Veterans Administration Hospital, Fort Howard, Maryland.

PSYCHIATRIC RESIDENCIES AVAILABLE: University of Washington and Seattle Veterans Administration Hospital; 3 and 5 year integrated program. For information write: Chief, Psychiatry and Neurology Service, VA Hospital 4435 Beacon Avenue, Seattle 8, Washington.

RADIOLOGY RESIDENT FOR APPROVED program at large teaching hospital beginning July 1, 1959. Contact Medical Director, San Joaquin General Hospital, French Camp, California.

PRINTING AND RECORDS

PATHOLOGY RESIDENCIES: Fully approved 4 year combined pathologic anatomy and clinical pathology program; 850 bed hospital with additional 135 beds under construction. 3 certified full time pathologists, 1 full time medical exfoliative cytologist. 1 full time PhD biochemist, 5 M.S. and 40 M.T. (ASCP) in clinical pathology divisions, which include Virus, Tissue Culture and Immunohematology Laboratories. 515 autopsies, 375,000 clinical pathology tests, 8134 surgical pathology examinations and 6000 transfusions performed during 1957. Active research programs with grants. Stipend: 1st year — $325.00 month for single and $375.00 month for married residents. Personal interviews at our expense arranged. Apply Arthur E. Rappoport, M.D. Director of Laboratories, The Youngstown Hospital Association, Youngstown 4, Ohio.

APPROVED INTERNSHIPS — Rotating, twelve available July 1, 1959, in 222-bed modern general hospital; also approved residencies in Internal Medicine, Obstetrics-Gynecology, and Pathology. Approval pending in General Surgery. Stipend, $300 per month plus full maintenance for interns; $400-$600 per month for residents. Opportunity to work with Board men in all specialties. Apply: Director of Medical Education, St. Francis Hospital, Honolulu 17, Hawaii.

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GENERAL SURGERY RESIDENCY—fully approved four year program affiliated with Louisiana State University and Tulane University Medical Schools. Salary begins at $3250 grading up to $4945. Applications are now being received for July 1, 1959. Must be citizen of United States. Write Chief of Surgical Service, Veterans Administration Hospital, 1601 Perdido Street, New Orleans, Louisiana.

RESIDENT OR ASSISTANT RESIDENT in Otolaryngology for January or July 1959 or sooner if available; A.M.A. approved residency and medical school training. Write: Chairman of Department, Box 25, 1200 E. Broad Street, Richmond, Virginia.

RESIDENTS WANTED

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1. Mullinos, M. G., and Jerzy Glass, G. B.: Gastroenterology 24: 385-393 (May-Aug.) 1953.

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